the MODERN HOSPITAL

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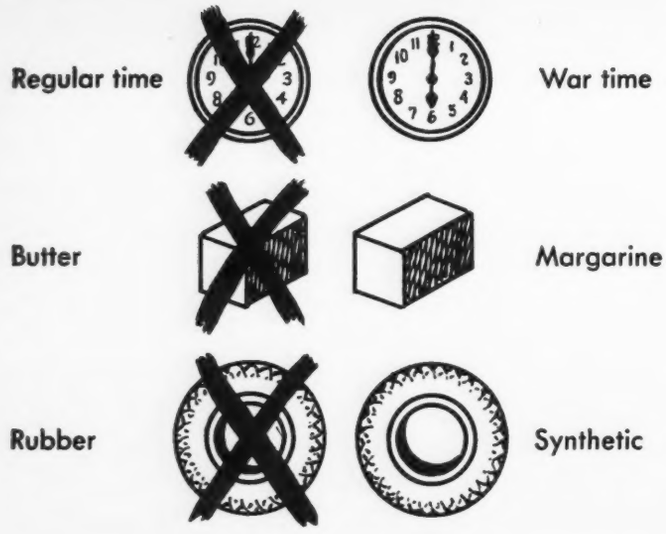

BUT

UNCHANGED SINCE PEARL HARBOR.....
WECK'S GUARANTEED ONE-WEEK REPAIR SERVICE

The American scene has changed almost completely since Pearl Harbor . . . WAR TIME has replaced regular time; margarine has put butter off the shelf; synthetic tires are shaming the products of the Jap-held Far East . . . but there is one thing that has REMAINED UNCHANGED.

That is something vitally important to every hospital — that's the WECK ONE-WEEK GUARANTEED REPAIR SERVICE. Re-read the guarantee at the left — especially that first paragraph wherein we guarantee to re-ship your instruments ONE WEEK FROM THE DAY THEY REACH the Weck BROOKLYN plant.

It has been a hard fight; there have been many temptations to raid the skilled staff of specialists in repairs — to put them to work making new instruments — but CONSERVATION being so important, the profit angle has been forgotten and the Weck Repair Service — personnel and service guarantee REMAIN UNCHANGED IN EVERY PARTICULAR.

If you have not tried the Weck service try it this week. If you have used it, use it again.

The "E" flag awarded Weck by the Army and Navy for excellence in production of surgical instruments.

Edward Weck & Co., Inc.

Manufacturers Surgical Instruments

SURGICAL INSTRUMENT REPAIRING • HOSPITAL SUPPLIES

135 Johnson Street — Brooklyn, N.Y.

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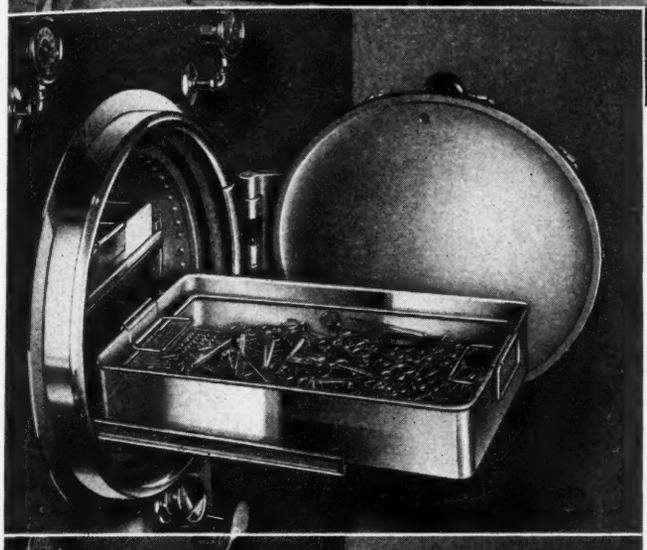

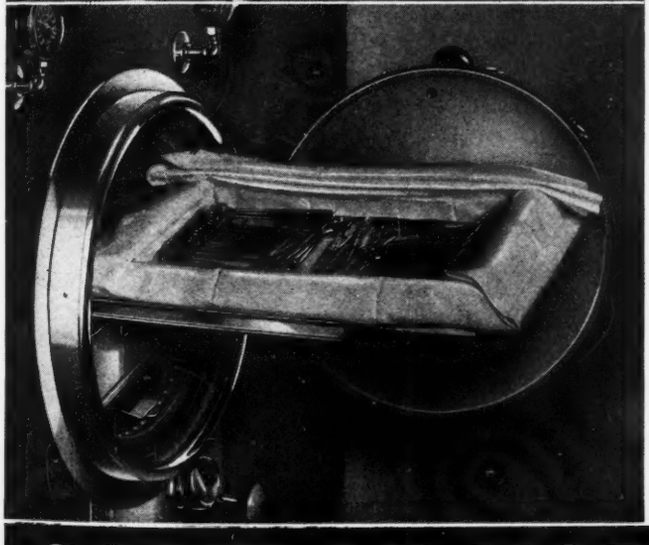

Time-Saving Techniques for Sterilizing Instruments

Autoclaving of instruments and utensils is preferred technique in many hospitals. It insures positive surgical sterilization in less time. It eliminates formation of scale on instruments and utensils. It permits the instruments and utensils to be removed from the autoclave practically dry. When equipped with the slide-a-way tray equipment illustrated at left, the autoclave is ideal for washing and sterilizing septic instruments.

Detailed information concerning modern sterilizing equipment will be supplied on request.

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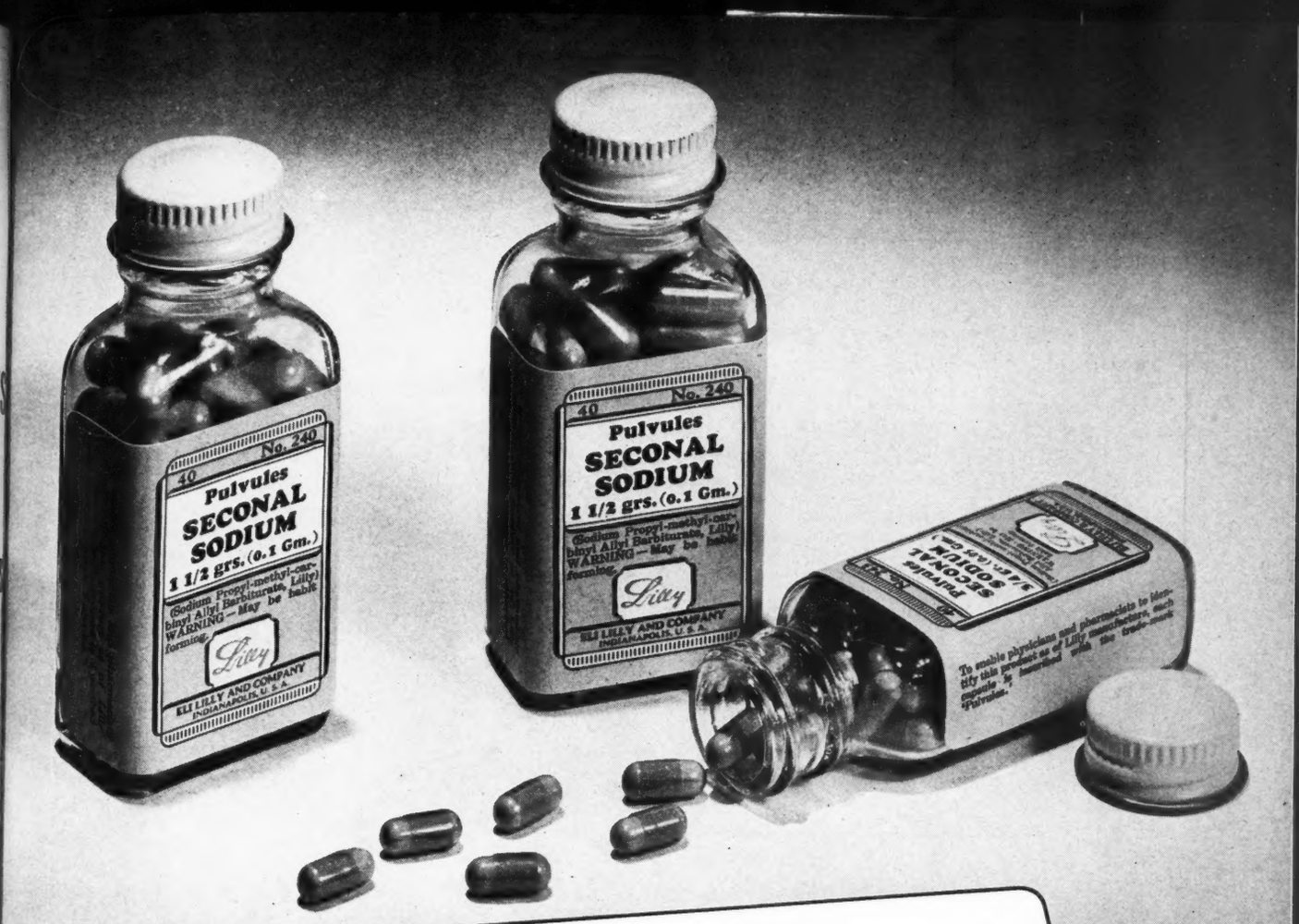
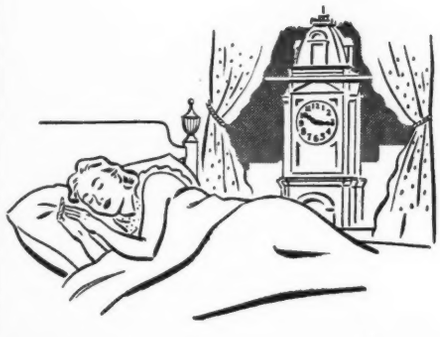


'Seconal Sodium'

(SODIUM PROPYL-METHYL-CARBINYL ALLYL BARBITURATE, LILLY)



ONE of the shortest acting barbiturates, 'Seconal Sodium' serves admirably to bring sound sleep without leaving after-effects of drowsiness next day. 'Seconal Sodium' also finds favor with obstetricians as a hypnotic during labor, and with surgeons as preanesthetic medication. 'Seconal Sodium' is supplied in 3/4-grain (0.05-Gm.) and 1 1/2-grain (0.1-Gm.) pulvules.

ELI LILLY AND COMPANY

Indianapolis 6, Indiana

THE ROVING REPORTER

Pumpkins and Public Relations

Remember the incident of the pumpkin vine belonging to a neighbor of the Paterson General Hospital, Paterson, N. J., described by the Roving Reporter in August? Because pumpkin vines have a habit of wandering all over, permission was sought for its peregrinations through the adjoining fence into the hospital grounds, in return for which the hospital would be the recipent of a couple of pumpkins. The hospital was willing but this pumpkin vine refused, judging from another letter recently received from the neighbor:

"You will probably remember me. I wrote to you in the spring asking permission to let our pumpkin vine grow on the property of the nurses' home and you were gracious enough to grant it. For your information, I am sorry to tell you that the vine has not done well at all and has not produced any pumpkins. However, with your permission we shall try again next year and hope for better luck. Thank you very much for your kindness."

This marks Chapter 2 in this little episode in public relations.

Improvised Foot Board

An important part of the Kenny treatment is the use of foot boards against which the patient's feet are pressed so that he will not forget the "feel" of walking. These boards are needed, too, for other types of cases, such as burns, to take the weight of bed coverings off the patient. Wood is getting scarce, however, and with an unusually severe infantile paralysis epidemic going on, Children's Hospital, Denver, was finding it difficult to get enough of the material to go around. The problem was solved with beaver board—it's inexpensive, easy to work with and, thus far, plentiful.

Eliminates Chance of Error

The presence of new and untrained personnel in every department of the hospital demands strict vigilance and precautionary measures to preclude the possibility of errors.

At Hamot Hospital, Erie, Pa., Donald M. Rosenberger, director, is taking no chances on the patient being dispatched to the wrong department for special treatment. A tag tied around his wrist bearing the name of the individual and the name of the doctor is a requisite. The supervisor or, when she is off duty, the nurse in charge is responsible for this identification before the patient leaves the floor for special departments.

Furthermore, the operating room and other departments have been notified that patients will not be accepted unless this identification accompanies them.

Home Talent to the Rescue

When the going was tough last summer in the dietary department of Emerson Hospital, Concord, Mass., with kitchen helpers and ward maids leaving to enter war production, the Hospital Aid Society came to the rescue with a group of "home talent." This comprised between 20 and 30 housewives who agreed to come two at a time one day a week Monday through Friday to wash the ward dishes, clean up the diet kitchens and help in the main kitchen by preparing vegetables and washing pots and pans when the dietitian was short-handed.

Edna Price, superintendent, cannot speak too highly of the service these women rendered. Each week a team captain was appointed whose responsibility it was to arrange transportation and

get substitutes when necessary. They worked from 9 to 11 a.m. and from 1 to 3 p.m. On Saturday and Sunday and during supper hours high school girls took over.

Safer, Quieter

"Heavy, heavy hangs over thy head." This line of patter from a childhood game describes a serious hazard in many hospitals in these days of inexperienced maintenance men. The dread of falling plaster hangs heavy over the head of many an administrator as an aftermath of leaking valves or flooded sinks on the floor above.

Several superintendents are sleeping more soundly, and their patients are doing the same, since the installation of a ceiling of perforated cane tile. The threat of falling plaster has been removed and the blessed by-product of sound control has been achieved.

Sr. M. Tharsilla, superior of St. Mary's Mercy Hospital, Gary, Ind., has used this treatment in a great many rooms and corridors. When the plaster was loose, it was removed first; otherwise the treatment was placed over the plaster. So attractive is the appearance of the new ceilings and so great a help are they in controlling sound that Sr. M. Tharsilla hopes to have the rest of the ceilings in the 200 bed hospital treated in the same way.

At neighboring St. Catherine's Hospitals, East Chicago, Ind., visitors and patients are happy with Sr. M. Cordula in the changes thus effected in the first floor corridor, the main office and the fifth floor. Sr. M. Cordula, too, is awaiting the day when the same type of treatment can be installed throughout the hospital.

Straight Shift Doubles Staff

The gloom of the nursing situation lifted at Batavia Hospital, Batavia, N. Y., when Mrs. Eva B. Berry put the girls on a straight eight hour shift. She found, upon experimentation, that the married nurses upon whom she must increasingly rely for service could not work a split shift and care for their homes and families at the same time.

So successful was the announcement of the straight shift that she was able to double the size of her nursing staff.

Another popular step at Batavia is the privilege granted the nurses of doing a double shift once a week. They may work eight hours, rest eight hours and then go back on for eight hours. Having accomplished this they then are able to have two successive days off, giving them a nice break for housekeeping or for recreation.

Like many hospital administrators, Mrs. Berry takes just as much of the local married nurses' time as she can get. Some have come back for two days a week, some for three, some for four. They are on the regular pay roll, getting $4 for the day shift, $4.50 for the evening and $5 for the night shift.

Aftermath of Boston Fire

The Boston fire of a year ago is still conversation in hospital circles. The quick and admirable accounts given by Massachusetts General Hospital men of the handling of a disaster such as might come any day to any institution have stimulated emergency medical administrative programs the country over.

Fire chiefs have also been shaken into action. At Johnstown, Pa., the fire chief came one day to Conemaugh Valley Memorial Hospital to make a more than usually stringent inspection. He made numerous suggestions, such as the removal of inflammable partitions, plastering and the installation of metal covered doors.

More serious was the requirement that the maintenance and paint shops be removed from the hospital basement. This transfer has now been made.

How thorough is the inspection of your local fire department and are any of its recommendations still uncomplied with?

READER OPINION

Questionable Yardsticks

Sirs:

In the August *Hospital Management,* Dr. T. R. Ponton presents an interesting geographical study of hospital distribution in the United States, the objective stated being "to determine the volume of general hospital service available—its quality and accessibility." He advances two new yardsticks—a 50 mile radius as the maximum area which a hospital may practically serve, and "in estimating the need for hospitals a required ratio of 2.5 beds per thousand is taken as the requirement of general hospital beds."

One cannot but wonder whether a qualifying paragraph was not inadvertently omitted for, certainly, 2.5 beds per thousand cannot be considered "a factor applicable to all communities." In sparsely settled districts this quota would be too high and in urban districts, too low, if past experience is any criterion.

The A.H.A. Committee on Hospital Planning and Equipment in its 1935 report on overhospitalization showed that hospital beds in rural areas averaged .95 per thousand and were used at 50.2 per cent capacity; that the urban average was 5.8 beds used at 62.4 per cent. The Hospital Survey for New York (1935), where the metropolitan area approximates Doctor Ponton's 50 mile radius, found 4.27 beds per thousand with 79.7 per cent occupancy.

If all who needed hospital care today could afford it, many more beds would be required. . . . Better hospitals bring more business. In many one-hospital towns an attractive new building has increased the patient census from 10 to 30 per cent in the first year.

Any attempt to use a one-dimensional yardstick to measure a many-dimensional problem is hardly practical. Accessibility, emphasized by Doctor Ponton, is obvious, but a 50 mile radius by road is today's figure; tomorrow's through the air will multiply the distance many fold.

From now on, all community hospital planning will be for postwar conditions and involve many new factors in standards, practice and policy. Today's yardsticks are obsolete. Hospital buildings will take on new proportions and hospital economics, new essentials.

Hospital planning must anticipate greater demands for hospital care, from both in-patients and out-patients and economic planning must make it possible for all to have it.

Management and medicine must exert themselves to create an effective coordinated program or resign themselves to government control. The hospital must operate as a business within its earnings. . . . Many voluntary hospitals are doing it now.

Doctor Ponton makes a real contribution in his graphic portrayal of bed distribution but, in the light of what the future holds, one cannot but question the validity of his yardsticks.

Charles F. Neergaard
Hospital Consultant
New York City

Queried Again

Sirs:

In publishing the map in the August 1943 issue of *Hospital Management,* Dr. T. R. Ponton performs a great service.

His discussion, however, creates a good many misconceptions. The principal fallacy is the conclusion that 2.5 beds per thousand is a reasonable standard for measuring the adequacy of general hospital beds in a given community. He states that his figures exclude all federal hospitals, special hospitals "and similar hospitals."

Although Doctor Ponton says that he is excluding only federal hospitals, an analysis of the figures which were published in the *J.A.M.A.* of March 27, 1943, shows that this country has 594,260 general hospital beds, which is equivalent to 4.5 beds per thousand of population. Of the above, 291,766 are governmental, namely, federal, state, county, city and city-county—equivalent to 2.2 beds per thousand. The nongovernmental general hospitals, consisting of church, nonprofit, individual, partnership and corporation, amount to 302,494 or 2.3 beds per thousand. The above calculations are based on the assumption of a population of 132,000,000.

Apparently, Doctor Ponton confines himself exclusively to nongovernmental general hospitals. All that he has a right to say, therefore, is that in planning a nongovernmental general hospital the 2.5 standard may apply to a community which already has at least 2.0 governmental general hospital beds per thousand.

Unfortunately, Doctor Ponton does not say that but gives the impression that, by and large, in planning general hospitals for a community, all that is necessary is to provide at the rate of 2.5 beds per thousand. It should be noted that the country already has 4.5 beds per thousand in general hospitals. This, together with several other factors, shows that even 4.5 beds per thousand is inadequate—*e.g.* Doctor Ponton's map.

Isadore Rosenfield
Architect
Department of Public Works
New York City

SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., Children's Free Hospital, Louisville, Ky.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; William J. Donnelly, Greenwich Hospital, Greenwich, Conn., and others

What Pay for School Help?

Question: We are employing high school girls, aged 16 and 17, as part-time workers. What is a fair wage scale for this group?—H.D., N. Y.

ANSWER: Approximately 25 cents an hour in the dietary department and $40 a month, plus one meal daily, in the housekeeping department.—FRASER D. MOONEY, M.D.

Maintenance Part of Income?

Question: We provide maintenance for our superintendent and technician who are on call at all times. They claim that their maintenance should not be reported as a portion of their income because they are on call. What are other hospitals doing about this?—C.F.G., N.C.

ANSWER: Under the 1942 income tax law, if quarters or meals are furnished to an employe by the employer, their value is to be included in the employe's gross income, unless they are (1) not considered as a part of wages at the time of employment and (2) are furnished for the convenience of the employer. The test of "convenience of the employer" is satisfied if living quarters or meals are furnished an employe who is required to accept them in order to perform his duties properly.

Under the victory tax, official instructions issued by the Treasury Department in November 1942 continued this exemption in the following words: "Quarters and subsistence would constitute remuneration unless furnished in the interest and for the convenience of the employer." The same exemption applies for the withholding tax.—A. B. M.

For "Good" Public Relations

Question: Isn't it wise judgment and sound business practice to invest the money required to promote a good public relations program?—R.Z.J., Idaho.

ANSWER: The key word in this question is "good." Money can easily be wasted in public relations, just as it can in hospital construction, in food service or in other functions. But a well-conceived public relations program is worth everything that it costs. In fact a hospital without such a program is probably allowing itself to drift into a dangerous situation.

A "good" public relations program must be based upon a sound concept of objectives, which are in the public interest. The purpose of such a program is to bring the hospital into close attunement with the desires and needs of the particular public which the hospital serves.

The program is a two-way street, designed not only to assist the public in understanding the problems and aspirations of the hospital but equally to enable the hospital to know and keep constantly in mind the changing problems of the public in its search for good hospital and health service.

In a small hospital it is rarely possible to engage a full-time public relations director to do the basic research, test public opinion, prepare material for newspapers and radio, obtain posters, cultivate the interest of the women's auxiliary and volunteers, make community addresses, prepare booklets, edit a house magazine, conduct hospital tours and do all of the other things that make up a well-rounded public relations program. In most instances the hospital administrator will have to assume many of these duties.

A good committee on public relations can be of great assistance to the administrator. This committee might also assume the responsibility of postwar planning for the hospital or should work closely with another trustee committee on this subject. The public relations committee could well include trustees, a few other prominent citizens, medical staff members, some interested department heads, the editor of the local newspaper and representatives of the women's auxiliary or volunteer groups. If carefully selected, these people will probably bring a variety of talents that will prove highly valuable in the hospital's public relations work. They must have some money for the tools they will use.—ALDEN B. MILLS.

Service for Less Than Cost

Question: Since the care of indigents (food, clothing and shelter) is a governmental function, why should hospital care be the only service such governmental bodies expect to purchase for less than cost?—E.R.C., Iowa.

ANSWER: Governmental units cannot name their own purchase price for any commodity or service they purchase except that of hospital care. A city or county cannot buy an 11 cent loaf of bread for a relief client for whatever price it chooses to pay. Yet governmental units tell the voluntary hospital to sell its $5, $6, $7 or $8 hospital service day for $2, $3, $4 or $5 or whatever the city or county chooses to pay.

Why do our hospital administrators and the influential members of our governing bodies stand for such unfair treatment? How much longer do we think that surplus from our private patients' income from our endowments and unfairly low pay to our employes will permit us to carry this burden? We hospital administrators and our board members are due for a rude awakening.

Voluntary hospitals cannot continue to assume this staggering burden. Governmental agencies must give more help. If the federal government really wants to improve the hospital situation, let it help the states to finance adequate social welfare programs, foster cooperation among federal, state and local government agencies, voluntary hospitals and the medical profession in working out complete hospital and health programs for each community and give federal grants to build hospital additions where needed.—EVERETT W. JONES.

Thinks Roof Gardens Impractical

Question: Our ladies' auxiliary is doing some postwar planning of its own and wants to start now on plans for an attractive roof garden for convalescing patients. Ours is a 110 bed general hospital. We have two solariums on each floor which, so far at least, are not in emergency use for bed cases. Do you think that installing a roof garden would be the best use of funds? We do need new equipment, when the government releases it.—M.W., Ill.

ANSWER: Roof gardens have been overdone, in my opinion. It takes personnel to accompany patients to the roof to watch over them while they are there and to escort them back to their rooms. Recreational facilities are better placed on the patients' floor, an accomplished fact in this instance. Try by some subtle persuasion to switch the good ladies over to financing the needed equipment.—CARL A. ERIKSON.

Deduct Taxes on Temporary Jobs?

Question: We frequently employ student nurses for a day or two during the month. Should we deduct victory and withholding tax in such cases?—C.F.G., N.C.

ANSWER: All employes, irrespective of the length of their employment, are subject to the withholding tax. When wages are paid for a period that is not a regular pay roll period, the withholding exemption is the daily exemption multiplied by the number of days worked in the period. Victory tax, of course, is no longer collected as such.—J. P. McD.

HEADLINE NEWS

NOVEMBER 1943

Status of Physicians Under Employment Stabilization Program Clarified by W.M.C.

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—A War Manpower Commission field instruction dated October 13 and directed to all regional manpower directors defines the status of physicians, dentists, veterinarians, sanitary engineers and nurses under employment stabilization programs. It specifically exempts nurses from the employment stabilization program. The instruction states, in part:

The great bulk of persons engaged in these professions are either self-employed or employed by government agencies, federal, state or local. Hence, by far the greater number of these professional workers would be exempt from the controls established by employment stabilization programs even if no specific provisions for their exemption were made.

There are, however, 90,000 persons out of a total of 600,000 in these professions who are employed by such organizations as hospitals and industrial companies. In the absence of any special provision these professional persons would be subject to the same restrictions on hiring (*i.e.* presentation of a statement of availability or referral by the local office of the U. S. Employment Service) as are applied to other workers covered by employment stabilization programs.

In view of (a) the small number of persons involved, (b) the technical nature of work done by most of the persons in these professions and (c) the existence of an effective mechanism of allocation through administrative procedures developed by P. and A., no person in these professions is subject to the controls set down in employment stabilization programs.

The exemption of these persons, however, relates only to the manner in which their obligation to serve where they can be of maximum value is indicated to them. Exclusion of persons in these professional groups from the controls established by employment stabilization programs has no effect whatever on the essentiality of the activities in which these persons are engaged.

The size of the staff of deferred interns and residents who will be granted to a given hospital is made contingent upon the hospital's agreement to limit the number of men disqualified for military service and the number of nurses who will be employed. This ultimate authority, however, is, in practice, rarely invoked and the size of house staffs and nursing staffs is determined by voluntary arrangements.

So far as the employment of persons in these professions in industry is concerned, the ultimate authority of P. and A. to arrange for deferment gives it authority adequate to permit their most effective distribution.

MORE SCRAP NEEDED NOW

All types and grades of scrap will be accepted in the "Victory Scrap Bank" drive which opened October 1 and will extend to November 15 in an effort to ensure a continuing flow of vital war armaments. Representatives of steel companies and scrap dealers throughout the country have urged the need for the drive, pointing out that they have on hand about 7½ million tons which will last only two months.

More Instructors Needed in Schools of Nursing

WASHINGTON, D. C.—The U. S. Cadet Nurse Corps recruitment program has intensified the need for qualified instructors in schools for nursing and all-expense scholarships have been made available under the Bolton Act, Lucile Petry, director, Division of Nurse Education, announced October 13. Schools of nursing were urged to select from their graduating classes members who show promise as instructors. The graduates, in turn, were encouraged to apply to colleges and universities offering the desired type of postgraduate education.

Graduate nurses now on teaching staffs of schools of nursing may also apply for scholarships. Instructors holding positions for which they are not fully prepared and those who qualify for advancement are advised to apply for scholarships for additional training in their chosen fields.

Miss Petry advised schools to pool instructors and to make all possible use of nonnurse instructors and part-time instructors. Clerical and other nonteaching duties should not be added to the burdens of instructors, she emphasized. Student nurses in the senior cadet period of training may be appointed to serve as assistants to nursing arts and clinical instructors, Miss Petry further advised.

Nurses Exempt From Provisions of W.M.C. Employment Program

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—The War Manpower Commission cannot compel nurses to accept duty with the armed services even though they are classed as available, declared Dr. Maxwell Lapham, executive officer, Procurement and Assignment Service, at a special meeting for nurses in Washington on October 7. It was disclosed at the meeting that the District of Columbia has supplied less than one third of its 1943 quota of nurses for the armed forces.

Pressure of public opinion, cooperation of hospitals, doctors and other employers of nurses and similar forces must be relied upon to get nurses into military duty, Doctor Lapham said. Nurses will be exempt, he announced, in the future from provisions of W.M.C.'s employment stabilization program and will not need certificates of availability from their former employers or referral by the U.S.E.S. to shift jobs. Women who leave essential jobs to enter nurse training must have such certificates or referral, he added.

It is rather appalling that the District of Columbia has supplied only 155 of its 1943 quota of 480 nurses, Louise A. Baker, assistant executive officer in charge of the nursing division of P. and A., declared. Staff nurses in hospitals and nursing education personnel generally are performing essential work, she said, but those eligible for military service will continue in this classification only until replacements can be trained among nurses who are over 45 or who have small children. Nurses in doctors' offices are usually not essential and, if essential, should be replaced by nurses who are ineligible for military service.

Many hospitals are using nurses for duties that can be assigned to nurses' aides or other lay personnel, Miss Baker declared.

W.M.C. Revises Stabilization Plans to Keep Essential Workers on Jobs

WASHINGTON, D. C.—Nation-wide provisions designed to assure the transfer of workers to war jobs and to keep essential workers already on war-useful jobs where they are were put into effect on October 15, according to announcement by Paul V. McNutt, chairman, War Manpower Commission. Most of the 200 area employment stabilization plans were revised to include the national minimum standards.

These standards make the following provisions:

1. A new employe who during the preceding sixty day period was engaged in an essential or locally needed activity may be hired only if (a) he is hired to work in an essential or locally needed activity or for work to which he has been referred by the U. S. Employment Service, and (b) he presents a statement of availability from his last employment or is referred by the U.S.E.S.

2. A statement of availability should be issued by the employer if (a) the worker has been discharged, or (b) laid off for seven days or more, or (c) continuance of employment would involve undue hardship, or (d) his wage or salary or working conditions are below standards established by law or regulation, or (e) his wage or salary merits adjustment according to W.L.B. but has not been adjusted.

3. The U.S.E.S. shall issue a statement of availability if the employer should but refuses or if the employer fails to comply with any W.M.C. stabilization program, regulation or policy.

4. If an employe is employed less than full time or at work not utilizing his highest recognized skill for which there is a war need, the U.S.E.S. upon his request will refer him to other available and more suitable employment.

5. A new employe may not be hired solely upon presentation of a statement of availability but may be hired only by referral by or arrangements with U.S.E.S. if he comes to or leaves a critical employment, or has not lived in the locality for thirty days or was formerly employed in agriculture.

Employers were urged by W.M.C. on September 24 to adopt part-time split shift arrangements for women workers who have home responsibilities.

Employe suggestions designed to increase production may be rewarded by cash bonuses without approval of the W.L.B., if the awards are actual and reasonable compensation for the suggestions and are not hidden wage increases, W.L.B. ruled on October 7.

Federal Control Established Over Sales of Fluid Milk

WASHINGTON, D. C.—Federal control over fluid milk sales through the establishment of milk quotas on deliveries of milk, cream and milk by-products went into effect in 13 eastern and midwestern metropolitan areas on October 4.

Hospitals will be protected in their milk requirements insofar as supplies permit, an official of W.F.A. said in an interview October 6. The basic purpose of the program is to prevent a further increase in the consumption of fluid milk so that enough milk will be available to produce the cheese, butter and other manufactured dairy products required by the armed services and civilians.

Milk dealers in the 13 initial sales areas will be allowed to sell as much fluid milk each month as they sold last June (1943), the peak production month. To help assure that enough fluid milk will be available during the season of low production to enable dealers to sell as much as their quotas allow, cream sales will be limited to 75 per cent of the quantity sold in June, and the sales quota for fluid milk by-products as a group (including cottage cheese, chocolate milk and buttermilk) also is set at 75 per cent of the June sales.

Milk distributors will be responsible for the fair distribution of supplies in their markets. Under Food Distribution Order No. 79, however, the various market agents may recommend distribution schedules to assure that, in the event of short supplies, the *most essential needs will be met first*. Hospitals and similar institutions will have priority in such emergencies.

Six Food Items Put Under New Government Restrictions

WASHINGTON, D. C.—Rice, sauerkraut, peanut butter, tongue, eggs and milk were affected by government actions taken during October. The news about eggs appears in the Food Service section of this month's issue and the news on milk is told in another news story.

Rice is not rationed but is under controlled distribution, with allocations to the different states in proportion to their normal consuming habits, the Food Distribution Administration announced on October 12. Distributors must spread available stocks equitably.

All stocks of sauerkraut in the hands of packers on October 12 were frozen for government purchase for military use.

Ration points are required to buy all varieties of tongue, O.P.A. announced on October 11, to clear up confusion on this matter.

Peanut butter prices were reduced by making rebate payments to peanut butter manufacturers, according to an announcement by W.F.A. and O.P.A. on October 2.

Puerto Rico Outlines Plans for Five New District Hospitals

SAN JUAN, P. R. (Special Correspondence)—A master plan for covering the whole island of Puerto Rico with adequate governmental hospitals will be presented at a public hearing in the near future, Dr. Rafael Pico, chairman of the island's planning board, announced on September 23.

Tentatively the plan calls for five more district hospitals with a capacity of at least 300 beds each and in some cases with a capacity of 600 beds. These institutions will be situated in Mayaguez, Ponce, Guayama, Caguas and Hato Ray. There are four district hospitals at present.

The project calls for an appropriation of insular funds of $3,500,000. Although the insular legislature approved in 1942 an act for the construction of three additional district hospitals, construction has been held up by W.P.B.

No information is available regarding the construction of military hospitals for security reasons.

Army Needs More Doctors in Spite of Reduced Quotas

WASHINGTON, D. C.—The Army has sharply reduced its requirements for physicians but is still short of present needs, according to a summary prepared by the Office of War Information and released on October 20. The Dodge Commission, immediately after the Spanish-American War, made findings upon which regulations of the Army were based. These called for a ratio of 8.5 doctors per thousand men. Since March 18, however, the Army has reduced its demand to 6.6 doctors in combat areas and 4.6 doctors in nonbattle areas.

The changed ratio works out to 53,000 civilian doctors for the Army and Navy, of whom 46,000 had been commissioned as of August 15. Even with this reduced total, commissioning of doctors is falling behind monthly quotas assigned.

LOOKING FORWARD

Personnel Bottlenecks

THROUGH the Bolton Act and the work of the Public Health Service, the War Manpower Commission, the Office of Civilian Defense, the Office of War Information and other agencies, the federal government has aided greatly in meeting the shortage of nurses. While the nursing shortage is not yet licked, civilian hospitals and the nursing organizations deeply appreciate the prompt and effective recruitment that has already been done and is now under way.

Now other shortages are showing up more strikingly. Some of these threaten to impede the proper development of the Cadet Nurse Corps program. Nurse anesthetists, medical laboratory and x-ray technicians, dietitians, medical record librarians and occupational and physical therapy technicians are all badly needed.

Mrs. Gertrude L. Fife reported recently that the demands for nursing personnel have so depleted the supply that several well-established courses for nurse anesthetists have been obliged to suspend. To meet this situation, she suggests that hospitals should select nurses who are interested in anesthesia and send them to school at hospital expense. Otherwise, hospitals may soon find that they have plenty of student nurses but a great shortage of nurse anesthetists. Some hospitals have already adopted emergency operating room schedules because of the shortage of nurse anesthetists. In most areas the shortage of physicians precludes turning to them to take up the slack.

Dr. Lall G. Montgomery, chairman of the Registry of Medical Technologists, has recently compiled all available figures on the shortage in this field. The needs of the armed services as well as the increase in number of hospital patients have made the situation acute. Yet Doctor Montgomery reports that probably only 700 or 800 applicants will present themselves for examination this year as compared with about 1200 per year in the past. "Many of the approved schools are finding it difficult to fill their classes and some of them are closing their schools because of the lack of a sufficient number of suitable students," he states.

The registry has appealed to all clinical pathologists and to all technicians to help find suitable students. The former were also requested to train apprentices, if possible. Doctor Montgomery also suggests that aides be used to clean glassware, carry reports, collect specimens and requisitions, keep files, answer the phone, prepare and fill culture tubes, run sterilizers and do other nontechnical tasks. Such assistance will help in the larger hospitals but will be of no avail in the small hospital that has lost its one and only technician.

At least 700 dietitians are now serving with the Army and it is probable that as many more are needed. Veterans Administration hospitals need 30. Nearly 400 are known to be needed by civilian hospitals. If enough qualified home economics graduates can be found, there should be an increase in the openings for student dietitians in hospitals.

Similarly, the registration in approved schools for medical record librarians is extremely low and one school has suspended for the duration. Shortages are reported for x-ray technicians, occupational therapists and physical therapists.

It would be helpful if the publicity emanating from hospital sources, nursing groups and, particularly, the federal government would incorporate some reference to these other shortages in hospitals along with the urgent need for nurses. Young women who may have no interest in bedside nursing might thus be encouraged to find a suitable vocation in the hospital field.

Many hospitals have allowed trained personnel to leave for better paying positions and then found that they had to pay as much or more for untrained substitutes. That is poor economy.

Pensions for Those Who Serve

IN THIS issue appears an article by Dr. O. F. Ball and Robert F. Spindell on pension plans for hospital employes. This is the first of several articles that will bring to the hospital field a full understanding of the need for such plans and the details concerning cost and benefits.

Probably the federal social security program will soon be broadened so that unemployment and old age

benefits will be available to all hospital employes. This progressive step has already been delayed far too long. But the federal program is not adequate. The low levels of old age benefits provide only for a miserly existence, not for a satisfactory retirement for those who have given long and useful service to mankind.

Now that the financial condition of hospitals is much improved it is possible to think in terms of the long-range strengthening and development of our institutions. One of the best steps is to build in the employes a sense of security that will make them eager to continue to give their best to hospital service. A good pension program, either with or without social security benefits, is a valuable contribution to their morale.

A Thought for Transportation

THE load upon railroads, truck lines and other freight-moving facilities is so enormous that every effort should be made to ease the situation. In a communication to The Modern Hospital, the Office of Defense Transportation has requested that hospitals be asked to cooperate in a voluntary program of spreading the transportation load throughout all twelve months to minimize the normal seasonal upsurges of traffic.

Of course, many commodities are not susceptible to adjustment of shipping schedules. Some are perishable or are available only in accordance with certain production schedules or their purchase is controlled by W.P.B. restrictions on inventories. But some products, such as coal and certain standard supplies, can well be stockpiled.

Hospital purchasing is daily becoming a more complex and difficult job. When possible, however, hospital administrators and purchasing agents should give thought to the transportation of their purchases and should cooperate with dealers or with other hospitals in the consolidation of loadings, elimination of unnecessary haulage and reduction of long-distance transportation. The load on the railroads varies in different localities but is usually highest in the fall and winter.

Federal Payments to Hospitals

WHILE there is some dissatisfaction in hospitals with the program of the Children's Bureau for paying for the maternity care of wives of servicemen and the care of their infants on a cost basis, we should be careful not to "throw out the baby with the wash-water."

The adoption of the cost formula by the Children's Bureau in connection with the crippled children's program some years ago was a decided gain for hospitals. It represented an acceptance of an important principle. This principle had been worked out in a few places, such as in Ohio for workmen's compensation cases, but had not generally been accepted by the federal government.

Recently, the Children's Bureau has amended the method of computing cost so as to eliminate most of the objections of hospital administrators. If other valid objections still exist, these will doubtless be eliminated in time. Congress has passed and the President has signed a bill making a deficiency appropriation of $18,600,000 to carry on the program and to meet the needs of those states whose allotment of funds has been exhausted.

Many of the complaints that have been leveled at the program are due to innovations suggested by the state officials and are not part of the federal government's plan. Because this method of payment may set a precedent for other federal programs, particularly for the care of women in the armed services, it is important that it be fair and equitable in all regards. But if hospitals complain too much about minor difficulties, if we do not cooperate readily in supplying the necessary figures, if we make the administration unnecessarily costly, we may lose an important advance.

Incidentally, the need of computing cost on a simple but reasonably uniform basis will serve as another strong argument for the extension of uniform hospital accounting, a goal that American hospitals have been seeking for forty years.

The Butter Racket

UNDER an act passed by Congress in 1886 and amended frequently since that time, taxes are levied on the manufacture of oleomargarine. "Manufacture" is defined to include adding coloring matter. The regulations state that a liability for tax is incurred by a sanatorium, hospital or any charitable, religious, educational or other institution if it colors the oleomargarine for the use of inmates or employes of the institution. Governmental institutions, however, are exempt.

Hospitals that wish to serve colored oleomargarine must pay an annual license fee of $600 and, in addition, must pay 10 cents for each pound used. The Joint Purchasing Corporation has pointed out that an institution using 120 pounds per week would have a combined tax liability of $1200, or approximately 20 cents a pound. This obviously is designed to be and is prohibitive.

In view of the present shortage of butter and the high nutritive properties of much oleomargarine now on the market, this law is working a real hardship on voluntary hospitals. The law is apparently designed primarily for the profit of the dairy industry and not for the welfare of the American public. Whatever may be done for the interest of the general public will probably need to come from pressure by consumer groups.

Voluntary hospitals, however, should protest strongly the unfair and discriminatory character of this law and should insist that they have equal treatment with governmental hospitals.

Have you considered a Pension Plan?

OTHO F. BALL, M.D.
and
ROBERT F. SPINDELL

FOR a long time the trustees and superintendents of hospitals throughout the country have recognized the need for a reappraisal of hospital compensation programs.

This need has obviously been greatly accentuated by the severe loss of personnel to the war services, to war plants and to other business concerns that pay higher compensation, on the one hand, and by the limitations of the wage stabilization program, on the other.

Most of our hospitals today are confronted with the very real problem of retaining even those employes whom they considered members of their permanent staffs and with the corresponding problem of attracting new employes.

From the very beginning hospital employes have felt a calling somewhat comparable to that of doctors or ministers; they have been at least partly motivated by the unselfish Christian desire to help others in distress. This attitude and the limited funds available for hospital salaries had the expected and accepted effect of a lower level of salaries for such employes than for employes in almost any other business or institution.

We must now reexamine these two reasons for the lower compensation of hospital employes to determine whether they will satisfy the requirements of the efficient hospital today and in the years following the war. Those who manage hospital staffs daily see the inability of the call of the hospital work to prevent valuable employes with many years of service from leaving for more lucrative positions.

We cannot say that these people are losing their unselfish spirit of service, for the increased cost of living and the high salaries paid to their friends and relatives in other fields are sufficient to tempt the most devoted. Yet some hospital superintendents have sensed in recent years —indeed, during the last decade—a lessening of the spiritual and an increase in the material factor as an inducement in hospital compensation.

Two other factors of much greater significance have occurred which, in the opinion of most hospital administrators and trustees, demonstrate the inadequacy of the present system.

The first is that the tremendous growth of hospital use by reason of the Blue Cross plans has increased greatly the number of employes needed to operate our hospitals. This demand has exceeded the supply of those who are willing to work in the hospital partly because of love for their work and the satisfaction derived from helping the ill. Therefore, to acquire a competent, adequate and efficient staff of permanent employes today, something more must be paid to them than their present relatively low salaries.

The most effective methods for meeting this need, in our opinion, are not merely to raise salaries so far as conditions will permit but to make a strong inducement to em-

ADVANTAGES OF PENSION PLANS

1. The pension plan does much more in solving the increased compensation problem than does any other form of compensation.

2. Compensation through a pension trust is the only method by which employes' compensation may now be increased without obtaining ultimate approval of the War Labor Board or the salary stabilization unit of the Bureau of Internal Revenue.

3. The pension plan will help hospitals retain their present employes and reduce turnover both now and in the postwar years.

4. It will serve as an incentive in attracting competent new employes.

5. It will bring hospitals abreast with the other quasi-public institutions and with comparable governmental bodies that have had pension plans for their employes for many years.

6. It will improve morale and efficiency and throughout the years may well pay for itself in this way.

7. Competent young men and women will be encouraged to enter the hospital's employ and to remain there if they understand that older executives will retire at a given age and that they will have an opportunity for promotion.

8. Replacement of superannuated employes by younger more aggressive and more progressive men and women will keep operations abreast of growth both in medicine and in business management.

ployes to come and to stay in the form of an attractive pension plan. More will be said on this point later in our discussion.

The second important factor that has fundamentally changed the compensation picture is the amazing growth of private and public pension plans throughout the United States since the advent of federal Social Security in 1937. Charitable, educational and like institutions, including hospitals, are not now included under the Social Security Act, although it is expected that they will be included under some future law.

Employers recognize, however, that the pension payments provided under the Social Security Act are inadequate and they have proceeded to supplement them by substantial pensions provided in their own private plans. Long before the Social Security Act there were thousands of employes' pension plans in effect in this country, *and among the most important of these were the pension plans for ministers, teachers and many different groups of municipal employes.*

Removes Fear of Future

Here is the essence of our point. In institutions in which the employes' compensation was below the level in business concerns, the trustees or governmental authorities, depending upon the body concerned, supplemented the lower compensation by the effective promise of adequate incomes for retirement. Once the employe could be shown that he would not have to save part of his low income to provide for his old age, he could release his present salary for current expenditures with relief of mind from the overhanging fear of poverty in old age. To women employes, even more than to men, this provision for the future was of vital importance.

How to Meet the Expense

Most of these pension plans in quasi-public institutions, to which category hospitals necessarily belong, are contributory. The employes thought so much of the need for retirement incomes that they induced the trustees or governmental body in charge to set up pension plans whereby the institution or the governmental body would match the contributions made by the employes out of their own present inadequate compensation. Today the trend is more toward a larger share or all of the contribution by the employer; this is a problem that will vary with each institution.

The phenomenal growth of Blue Cross plans and related projects, with the resultant increase in occupancy so that most hospitals are taxed to capacity, demonstrates that hospitals can now afford to undertake pension plans for their employes, apart from the fact that they will certainly be compelled to increase compensation in some form from now on. When the demand exceeds the supply, a fundamental law of economics is that a higher price will be charged for the product or service supplied. The operation of this principle everywhere today is altogether too vivid.

To return to our point: if a few cents a hospital-bed-day are added to the present charges, sufficient money would be produced, without noticeable effect, to provide an adequate pension plan for all permanent employes. Each hospital will, of course, have its own definition of the term "permanent employe," but in most cases it will probably include those who have been in its employ three or four or five years.

A study of the figures required for a typical pension plan demonstrates rather quickly that the cost, while substantial, is not too large and that considerably more benefit can be achieved by an expenditure of a given sum in a pension plan than by an increase in compensation in any other given form.

Attracts Competent Workers

Aside from the compensation problem, private pension plans have frequently been considered by employers as producing tangible results which in and for themselves more than justify the cost of the plans. One of these results is the definitely improved morale of employes. They lose the fear that has been hanging over their heads for years that they will have to stop working some day and will have no income to take care of them in the later years of their lives. They appreciate the employer's efforts in working out a detailed program for them and they show it in increased loyalty and increased effort.

It is axiomatic that to maintain progress and hold one's own in business, the older men and women—the superannuated employes—must, at the appropriate time, be retired and their positions filled with younger workers. The pension makes it easy to let the older employes go to enjoy the remainder of

their lives in leisure; and it encourages younger men to stay with the hospital, since they know they will be promoted when a man retires, instead of being required to await his death or incapacity.

A pension plan helps attract competent new workers. The head of a well-known business concern recently stated that 80 out of every hundred applicants now interviewed for new jobs inquire whether the company has a pension plan, whereas a year ago only a dozen out of every hundred made such an inquiry.

The foregoing discussion of the applicability of pension plans to hospitals and their employes demonstrates that there is a great need for such plans in the hospitals of our nation. The funds are available or can be easily raised in most cases.

From the point of view of immediate need alone, the pension plan has a great deal to offer and progressive trustees and superintendents will explore its possibilities. From the long-run point of view, we hazard the guess that before many years have passed private pension plans in hospitals will be the rule.

Next month we shall discuss in considerable detail a typical pension plan for a typical hospital of medium size. The cost of operating such a plan will also be presented.

Story *of a* Workshop

MAXIM POLLAK, M.D.

Medical Director and Superintendent, Peoria Municipal Tuberculosis Sanitarium, Peoria, Ill.

TO ACCUSTOM our former patients at the Municipal Sanitarium to the physical strain of normal occupations and to reestablish normal work habits, the Peoria Production Shop was organized in March 1941 at Peoria, Ill.

At the time the shop started we felt that it would matter little what kind of work the shop provided as long as the production did not require particular skill and as long as the workers received decent wages. It was deemed essential, however, that the shop be self-supporting so that the wages paid would reestablish in its workers the self-respect that follows a regular remunerative occupation.

We Make Safety Mittens

Because the financial status of the sanitarium did not permit it to invest money in the establishment of a shop, the W.P.A. was approached. The authorities approved the undertaking and assigned to the project seven sewing machines and one competent supervisor and instructor.

In the course of planning we were fortunate in interesting an officer of our leading industrial concern, who tried to find a way in which his corporation could utilize the work of the shop. He came to the conclusion that the safety mittens (made of canvas and leather) used in large quantities by his workers could be readily produced by our patients. So he placed his orders with us.

The small capital needed for the purchase of additional machinery for the production of the leather mittens and for the payment of wages until the shop received its own income was provided in the form of a loan of $500 by the sanitarium. Concerning wage policies it was decided that for the first weeks, until they had acquired the necessary skill, the patients be paid on an hourly basis and after that, on a piece basis. Lest the patients overtax their strength the maximum hourly output was predetermined.

An agreement was reached with the Relief authorities that as long as the weekly earnings of its clients did not exceed a certain limit their relief allotment would not be curtailed.

Moral Tonic for Workers

During the period of planning some apprehension was felt lest male patients object to sewing. This apprehension vanished after the project started and men and women took to their work with equal delight. As a matter of fact, the work in the shop has proved a real psychologic and moral tonic for all its workers.

There was the case of an electrician who, in the course of his treatment at the sanitarium, became despondent because he was separated from his family and could not support them.

When, after his discharge, he was permitted to work at the shop his whole attitude toward life quickly returned to normal. Today he is back at his old job, working full time in good health.

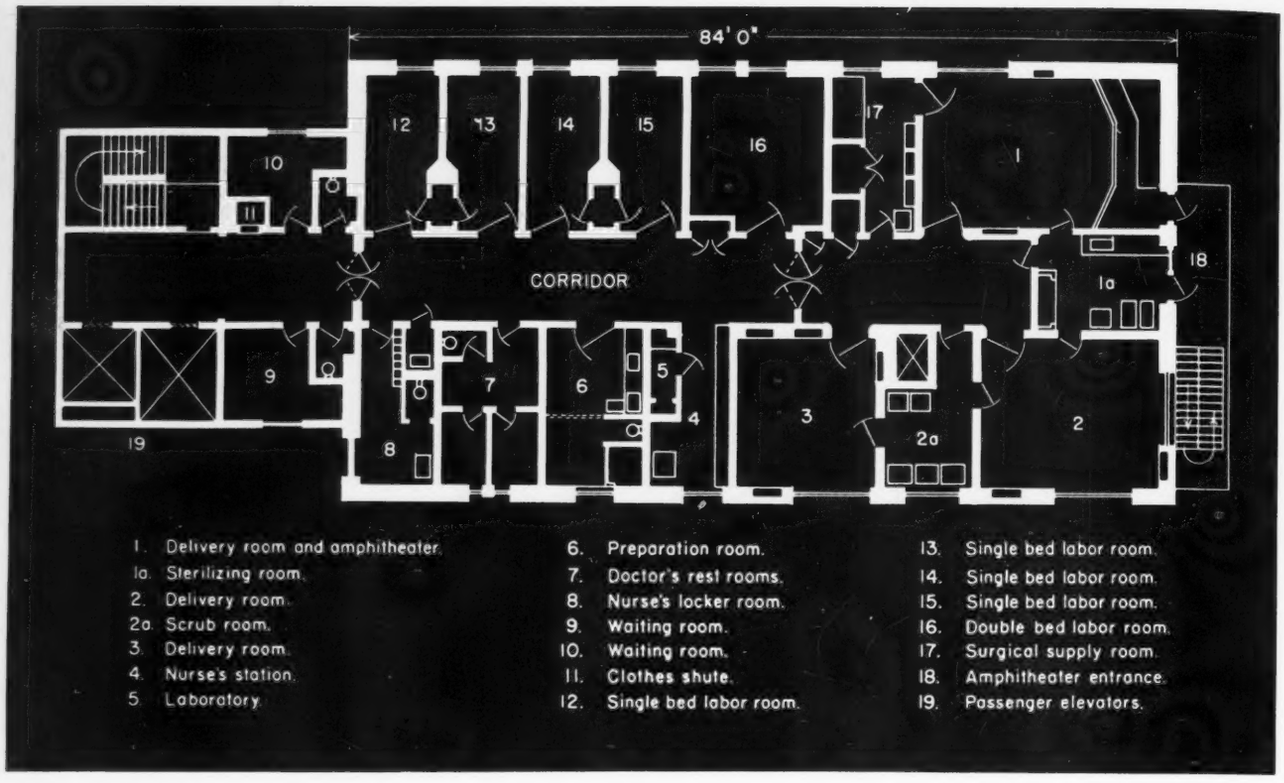
The story of a Negro patient is also worth recounting. Before her breakdown, she was a cabaret dancer. For four years she carried on a courageous fight against her disease and underwent a number of operations. Then the day came when she received her first weekly pay check at the shop. It was a pittance, the pay for one hour's work daily. But as it was given to her the tears of excitement and satisfaction streamed down her face.

Shop Is Self-Supporting

In the course of time the shop repaid its loan to the sanitarium and has earned a satisfactory capital, so that it has become truly self-supporting. Since the W.P.A. has been discontinued it is in a position to meet all its expenses without outside aid.

Today after two and one half years of operation we have proof that the shop was founded on sound principles and has been conducted on a practical basis. It has added the last and a most important link to our tuberculosis control program by leading our patients safely back to normal work.

Without this preparation patients might easily break down again at the crucial period of adjustment to normal workaday routine.



Stanford's Lying-In Suite

ANTHONY J. J. ROURKE, M.D.
Physician Superintendent, Stanford University Hospitals, San Francisco

OUR new lying-in suite has been constructed on the roof of one of the wings of Stanford Hospital, San Francisco, at a cost of $50,000. It is used only for patients in labor or being delivered.

The walls and ceilings of the entire unit have been treated with acoustical plaster or acoustical lath. There are two waiting rooms for relatives of patients in labor or being delivered. There are five labor rooms with six labor beds.

A linen closet located in the corridor facilitates the delivery of linen without the necessity for anyone entering a room and without a nurse being called. A pair of double doors separates the labor portion of the unit from the delivery rooms.

Throughout the delivery room portion, including the surgeons' scrubroom, nurses' workroom and sterilizer room, terrazzo flooring has been used. In the delivery rooms proper, brass grids were soldered together and grounded to the plumbing system.

Delivery room No. 1 on the plan is being used as the teaching delivery room; on one end is a students' gallery completely separated from the delivery room proper by plate glass. Students are able to enter this gallery without going through the unit, so that it is not necessary for anyone in the gallery to wear caps and gowns. An amplifying system, with a microphone in the delivery room and a radio in the gallery, allows the physician to talk to students during the delivery.

A preparation room has been included in this unit so that patients in labor may be admitted directly to it. There examinations and necessary preparations are taken care of before the patient is admitted to the labor room. Facilities for emergency laboratory work have been included so that urinalyses and emergency blood counts may be done immediately in the event that the central laboratory is closed.

Two bedrooms have been included for the use of obstetricians who have occasion to spend several hours in the unit.

In the construction of this unit we have kept in mind a functional goal. All door casings and the terrazzo base have been constructed in such a manner that no ledges are present to collect dust. Lighting in the delivery rooms has been accomplished by the use of fixtures flush with the ceilings so that here, too, dust has been eliminated.

Three delivery rooms are wired for both alternating and direct current with explosion-proof switches throughout. Suction has been piped from a central unit to the three delivery rooms.

VOLUNTEERS

1. Albany's Aides

MILDRED STEWART TUCKER

Director of Volunteers
Albany Hospital, Albany, N. Y.

THE volunteer department of Albany Hospital, Albany, N. Y., has grown like a mushroom in the last six months and is now composed of 538 active volunteers. Of these 128 are Red Cross nurses' aides, 57 are Gray Ladies and 353 are men and women volunteer aides. These 538 volunteers worked 9638 hours during the month of June.

Albany Hospital (600 beds) has sent to the armed forces General Hospital No. 33; in addition, many of the doctors, nurses and nonprofessional personnel have joined other Army, Navy and Marine units. Altogether 97 doctors, 68 nurses and 34 employes have entered the armed services.

The hospital tried to offset its nursing shortage with the invaluable Red Cross nurses' aides. These girls, recruited with care and discrimination by the Red Cross and given eighty hours of training by the hospital, slipped easily into the general routine and kept the hospital going through difficult times.

However, as the situation grew more and more desperate, it was found that a sufficient number of women able to give enough time to qualify as Red Cross nurses' aides could not be obtained. Another type of volunteer must be sought.

It was realized that there would have to be a coordinating center for the various groups of volunteers so a volunteer department with the same standing as the other departments of the hospital was installed. An office was provided and a director of volunteers who promised to give at least five hours a day was put in charge. A full-time paid secretary, a member of the hospital staff, was delegated to act as office manager and all volunteers then working were asked to report to this department.

Everything possible was done by the administration to help the new department and it was fed on such challenging statements as, "if there are not a great many more volunteers at once, the hospital will have to limit the census"; "we are now down to 73 general duty nurses (as against 186 last year) and they must be saved for the highest type of work"; "if you cannot get a large number of volunteers at once to do the simple jobs, we shall close a ward."

Newspaper publicity and appeals to the local war council, the Red Cross, the American Women's Voluntary Services and churches brought a fine response. The governor's wife, the bishop's wife (the mayor's wife was already a Red Cross nurses' aide), the hospital administrator's wife and the wife of the president of the board of governors, as well as many doctors' wives and housewives from all walks of life, answered the call.

Placing these willing women was more difficult. The hospital staff looked upon them not with a hostile eye but with a doubtful one. Nurses were too busy to train them. A volunteer, no matter how willing to serve, who asks the head nurse such questions as "Can I catch anything if I work on this floor?" "Where can I throw these dead flowers?" "What can I do now?" is a nuisance and who can blame a nurse for answering simply and succinctly "You can get out."

Each new volunteer feels that she can serve fresh water in the morning but even this simple task involves cleaning pitchers, sterilizing drinking tubes and understanding fluid intake charts, not to mention finding the necessary paraphernalia. To supply each one of the 50 patients on a floor with a clean pitcher of ice water and a glass without asking any question of busy nurses and without getting underfoot is in itself quite a trick. If a volunteer is to be of real use, she must be taught to proceed in accordance with hospital routine.

A lesson soon learned by the volunteer department was that an untrained volunteer is more of a nuisance than a help and may be a source of actual danger to the hospital.

As it became apparent that teaching and supervision were necessary, the nursing department offered to delegate a nurse to the volunteers for this purpose and her services were of the greatest value. A course of four two-hour periods was instituted and required and later two more two-hour periods were added. A minimum of six hours' work a week is required of all women volunteer aides working on the wards and private floors.

The first period is taken up by an hour's tour around the hospital after which the volunteer is given a list of forty odd places, such as offices, ambulance entrances, emergency and x-ray departments, drug room and laundry. She goes alone and checks off each place when she is sure she will remember its location. Each volunteer aide is required to be familiar with all fire escapes and staircases. In the second two-hour period the nurse demonstrates the procedure for attending to flowers, serving drinking water, care of bedside tables, assistance with trays and the feeding of helpless patients.

The next two hours are given over to bedmaking, including closed, ambulatory and postoperative beds, and the care of a room after the patient has been discharged. The third period is devoted to return demonstrations in which the student proves to her instructor that she can perform all the duties that she has been taught.

In the last four hours, recently added as the need has arisen, the volunteer aides are taught morning care, including bed baths, care of hair and teeth, making an occupied bed, applying scultetus and T binders, passing bedpans and the application of ice caps.

The instructor also supervises all the work of the volunteer aides on the wards and private floors.

Experienced Aides Wear Chevrons

Daily from 70 to 75 volunteer aides check in and are given their assignments. The same aide is sent to the same place as far as possible. Those working on the private floors and wards follow a definite routine. Those in the record room, diet kitchens, clinics, supply rooms, laboratories and workrooms are given directions on arrival at their posts.

Chevrons are given to women who have completed the course, who while working on the floors have been checked by their instructor as to their ability to perform each duty and who know the hospital.

These chevron aides are invaluable. Each day they go through the hospital several times to see where more help is needed and keep the volunteer office in close touch with the situation everywhere. They accompany new workers to their assignments and help orient them. They are expert in their general ward work, know every nook and cranny of the hospital and are able to take new aides on the required tour of the hospital.

Besides the chevron, tiny red stars are given for each hundred hours' service. Four will fit on the lapel of a uniform. None has yet reached the 500 hour mark and it has not been decided what kind of decoration will be given for that, the hospital being unable to supply diamond sunbursts.

The once doubtful eye of the members of the hospital staff has now been changed to an approving, not to say an acquisitive, one. The volunteer office is often hard put to fill the demands. "Please send an aide to make three beds, to discharge a patient, to put away laundry, to take prescriptions to the drug room, to take a patient to the x-ray department." "Have you someone who can type, who can sit with a sick and frightened child for a few hours, who can darn some blankets, who can help the printer deliver supplies?" "We have had 30 operations today and must have someone to help wash instruments."

A great difficulty is to fill all these demands, which are not constant but come in great waves, without keeping a row of volunteers sitting like a string of hall boys in a summer hotel waiting for a summons. The minute a volunteer is idle she feels superfluous and thinks of the unmade beds and unweeded Victory Garden awaiting her at home. Visions of her impatient husband who likes to have the little woman preparing delicacies for his dinner float before her eye.

To obviate the foregoing, a workroom has been set up in the solarium in charge of a trained employe and a group of volunteers is always working there making hospital supplies, sewing and mending. When need arises, these aides may be called on to serve.

Men's Division Is New

The men volunteer aides of the Albany Hospital are a comparatively new group as the shortage of orderlies was not felt as soon as the shortage of nurses. They were recruited by newspaper stories, appeals to the war council and talks to men's clubs. One hundred and thirty men gave 1746 hours of volunteer work during the month of June.

The men's division of the volunteer department has an office of its own, a volunteer chief, two paid secretaries (as the office is kept open from 9 to 9 daily) and a nurse to instruct and supervise.

Ten hours of training are required. After the first two-hour class, which includes the general organization, structural plan and tour of the hospital, the remainder of the time is given up to teaching the following duties: rectal temperatures, preoperative shaving, enemas, bedmaking, application of chest, abdominal and T binders, stretchers and wheel-chair instruction.

Many tasks too heavy for women are done by the men, such as moving oxygen tanks, taking patients on stretchers to the operating room or to the x-ray department, acting as the attendant on the ambulance or being on duty in the emergency rooms.

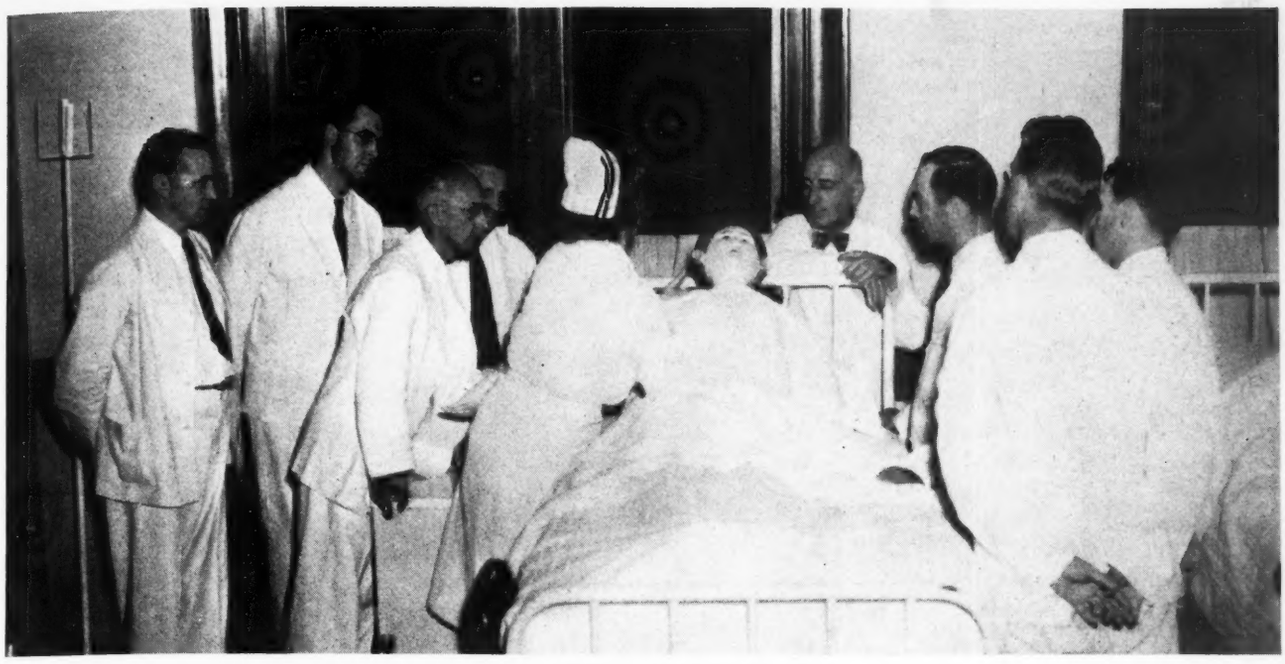
Men are desperately needed during the entire twenty-four hours. Plenty of men are on hand during the evening but it is difficult to find enough for the daytime and from 4 to 8 a.m. is the hardest time of all to fill.

Clergy Responds Eagerly

The work appeals to ministers and rabbis. Out of the six rabbis in Albany, four are working as volunteer orderlies. It appeals to men who have always wanted to be doctors. It appeals to those to whom circumstance has perhaps denied an opportunity for more direct contribution to the war and who are willing and eager to undertake an essential task.

At the completion of the prescribed course, which is followed by supervision and practical experience, a volunteer aide should emerge as a uniformed member of a homogeneous group thoroughly familiar with the hospital and able to perform certain duties quickly and efficiently, according to the accepted procedure. He or she should be punctual, dependable and loyal and should have acquired a professional attitude which forbids reading charts, visiting patients out of hours or entertaining acquaintances by choice bits of hospital gossip.

In the critical times of today the volunteer aide is indispensable and one wonders if the experience during the war will not lead to the department of volunteers being a definite part of every large hospital.



CLASS FOR VOLUNTEER ORDERLIES, LENOX HILL HOSPITAL, NEW YORK CITY

2. MEN Lend a Hand, Too

RAYMOND P. SLOAN

"IF THE women can serve, why can't we?" This question, raised less than a year ago by certain hospital-minded citizens when confronted with the seriousness of the labor situation in their institutions, they have answered by actual demonstration.

Men can serve, they are serving and they will continue to serve in increasing numbers as long as the emergency exists. From their origin in one or two large hospitals in the East men's volunteer corps are rapidly spreading throughout the country as far as the Pacific Coast, sponsored by either individual hospitals or some local agency in cooperation with civilian defense efforts.

Indeed, O.C.D. is making a national appeal calling all eligible men to the aid of their hospitals.

Pioneers in the formation of men's volunteer groups have established certain principles that might well be studied by every institution contemplating such projects. The pattern will naturally vary according to the type and size of the hospital and the community it serves.

The logical first step is the appointment of a hospital committee to determine what types of services are essential. This survey influences the training program and sets the pattern for the entire procedure. When the effort is initiated by a local civilian defense group, it is essential that a hospital administrator be placed in charge of the branch that is working in conjunction with the director of volunteers of each individual hospital.

Assuming that the hospital is inaugurating its own men's volunteer program, a committee should be appointed to organize the work. This would include, preferably, the administrator, the president of the board or some other trustee, the superintendent of nurses, the chief of the medical staff and whoever has responsibility for the management of the program. It becomes the function of this group to determine what types of service are needed and to establish the policies.

Next comes the appointment of a committee of citizens typifying those who are believed to be desirable registrants. In the New Haven Hospital Men's Volunteer Corps, which is frequently used as an example, this group included a teacher, Yale's football coach, a contractor, a men's wear merchant, the owner of an art gallery and a beverage distributor. To these might well be added an outstanding clergyman. The group, in other words, should provide a cross section of the community with each member thoroughly civic-minded.

A director appointed by such a group works with the hospital heads and assumes responsibility for the entire operation with division chiefs or chairmen reporting to him.

It may not be practical to provide as comprehensive a program as that set up in New Haven, which covers three original divisions: professional care, property care and operations. The general outline, however, is suggestive.

Four units are listed under each division. For example, under professional care come nursing service, technical service, dietary service and special projects. Under property care are listed buildings and grounds service, supplies and equipment service, laundry service and special projects. Under the operations' division are clerical and administrative service, ways and means, public relations and special projects.

The advantage of such a program is, of course, that there is a job to suit the interests and temperament of almost any man. There is no reason, however, why a limited program might not be instituted at the start with further expansion possible as the need arises.

The responsibility for the teaching program rests with the department head in conjunction with the volunteer committee. Hours and number of lecture and training periods vary. Here, for example, is how some eastern hospitals have set up their courses for volunteer orderlies.

At Mount Sinai the training program comprises two weekly sessions for three weeks, or a total of six sessions of three hours each. From an hour to an hour and a half is spent in didactic lectures or demonstrations and the same amount of time, on the wards. Both evenings of the fourth week are spent entirely with the orderlies on the wards, following which those volunteers who have attended regularly and who have shown aptitude for the work are given regular assignments.

The course at Lenox Hill Hospital includes fifteen sessions held twice weekly from 7 to 10 p.m. The first hour is spent in the classroom with two hours in the hospital.

Presbyterian Hospital's course is forty hours long, lasting over a period of ten weeks. A two hour session on Tuesday evenings is devoted to teaching and the same time on Thursday evenings, to practical demonstrations. New York Hospital's course runs fifteen hours.

In Rochester, N. Y., Strong Memorial Hospital's volunteer recruits receive a ten hour training program and additional instruction while on duty. Paterson General at Paterson, N. J., provides male volunteers with twenty hours of training given two evenings weekly from 10 o'clock until midnight for five weeks.

One Important Rule

One important rule always to be observed in handling volunteers is to assign them definite work schedules. Nothing destroys their morale more quickly than their being required to hang around with nothing to do after having made the effort to report for duty at a certain time.

A good beginning goes a long way toward a successful culmination of the training period.

VOLUNTEERS MEET MANPOWER SHORTAGE AT PROVIDENCE HOSPITAL, PORTLAND

Says Frederick D. Grave, director, New Haven Hospital Men's Volunteer Corps:

"The opening meeting of a class is of prime importance. Let the group know what type of hospital you are operating. The administrator or assistant administrator can best fill this assignment. The importance of the occasion deserves the attention of top people. Explain the rates and how they are arrived at. Explain the executive management and how it functions.

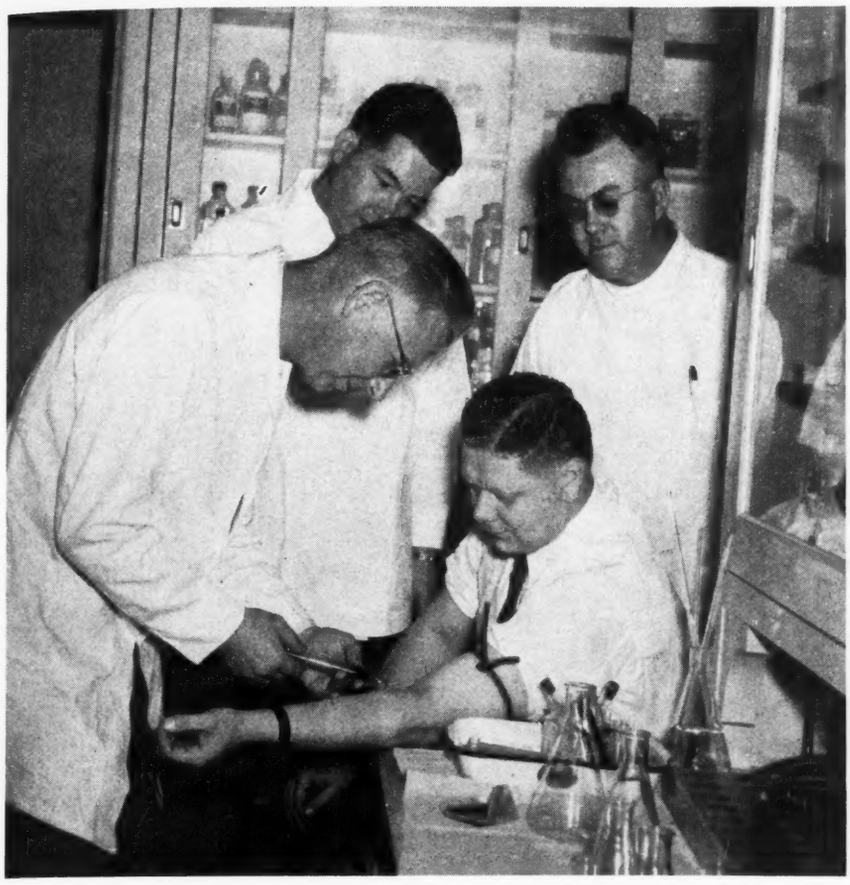
"Explain the need for male volunteer services. Make it clear that this is a war-time necessity to cover the absolute essential services and that it is not a luxury service. Make it clear that volunteers do not and will not replace potential workers, when and as they are available. Let the chief of staff express his appreciation for the effort the men are about to make and the supervisor of nurses say a few words on the shortage of nurses and orderlies, making the need clear."

As the demand warrants it, the schedules should be so arranged that the hospital is provided with volunteer assistance twenty-four hours of the day, every day of the week. It is expected in most instances that the volunteer will agree to give at least three hours of service weekly and that he will give at least one day's notice if unable to be present.

Much depends upon the type of men constituting the first recruits. Experience to date shows that best results are obtained by personal solicitation. For this reason the diversification of interests in members of the men's volunteer committee is important. Teachers, clergymen, lawyers, to say nothing of business heads, will draw from their own groups.

Paterson General Hospital has been particularly successful in contacts made with the local ministers' association. In consequence, its members are taking over the ambulance service from 10 p.m. until 8 a.m. What a significant commentary on the spirit of the times is the realization that, following his Sunday evening sermon, a minister will doff his clerical robes and dash for the hospital to serve as ambulance driver until morning!

To show from what diversified walks of life male volunteers may



CIVILIAN DEFENSE VOLUNTEERS AT WORK IN A PORTLAND (ORE.) HOSPITAL

be recruited, a list showing the membership classification at New Haven Hospital follows: accounting, 4; advertising, 4; banking, 9; building and contracting, 4; the clergy, 5; dentistry, 2; farming, 1; engineering, 2; education, 11; insurance, 11; investment, 7; law, 5; manufacturing, 24; merchandising, 22; art, 2; pharmacy, 1; railroading, 1; real estate, 3; retirement, 2; selling, 5; students, 1; utilities, 25; welfare work, 2; unclassified, 2.

In addition to individual contacts, it is possible to obtain recruits through letters, the local press and radio, through salesmen in allied medical fields and various volunteer organizations in the community.

General qualifications for men volunteers are described concisely by Mr. Grave of New Haven: "(1) men not likely to be called into the armed service but in general good health; (2) those known to be reliable, trustworthy and public spirited; (3) those who are careful but not timid; (4) those who will stick to the job, as demonstrated by their record in other public services; (5) a cross section of the community, cliques being avoided.

"Fundamentally," he adds, "all men of good character who have demonstrated their worth in the community regardless of race, creed or color between the ages of 18 and 60 are eligible."

Once men of the right type have been recruited and their training successfully accomplished there comes the problem of maintaining their interest. Herein lies one of the pitfalls of volunteer service. Too often the presence of these public-spirited men and women is taken for granted. As the need of hospital volunteers increases the importance of a follow-through program is recognized.

One of the first steps is to keep the paid personnel appraised of the functions of the volunteer. This requires a constant educational program because of the high turnover among employes. Nothing will discourage a volunteer more than the feeling that he is being exploited or imposed upon.

Most hospitals using male volunteers supply a practical uniform at low cost with identification insignia and service markings. At Rochester General this is white with a red and white marking on the breast. At New Haven Hospital the garment is a three quarter length, wrap-around jacket which provides complete protection. It has identification insignia; in addition, service stars are awarded each three months and are augmented by a service bar at the end of one year's continuous work.

Generally, the individual is responsible for the laundering of his own uniform, although it is felt by some that this obligation should rest with the hospital. Some institutions furnish the uniform at no cost or agree to supply any extras that may be required after the volunteer has supplied his first coat.

Some hospitals give the volunteer workers free physical examinations, including chest x-rays. Locker facilities with showers are considered essential. Meals are generally supplied during the period of the volunteer's service.

As part of its follow-through program New Haven Hospital holds monthly meetings of the entire corps for questions, answers and criticisms. Such a program may be augmented by a short talk by a member of the staff on blood transfusions, common colds and other subjects of general interest.

Occasional social gatherings are also planned to which special guests are invited, such as members of the staff, board members, civilian defense heads and friends. This hospital, too, supplies each active member with an appropriate windshield sticker.

Business Houses Release Men

Growing recognition of the importance of the services rendered by the men's volunteer service, as interpreted through radio, press and personal contacts, is likewise helpful in raising the individual's self-esteem. In some communities, Hartford, Conn., for example, certain industrial concerns release their junior executives when necessary during the business day to serve their allotted time in the hospital. Some local rationing boards, too, have been willing to provide volunteers with additional gasoline for traveling to and from the hospital in the performance of their duties.

It is the men's turn. With true conviction they have raised the question, "If the women can serve why can't we?" and have proceeded to answer it in terms of everyday performance.

3. *Have you overlooked* TEEN-AGED GIRLS *in training volunteers?*

CATHARINE W. MEIER, R.N.

Director of Education, Doctors Hospital, Washington, D. C.

MOST hospitals in seeking volunteers have overlooked teen-aged girls. Doctors Hospital of Washington, D. C., realized the potentialities of this group since the city was filled with idealistic and enthusiastic young girls, for whom there seemed to be no place to serve. We believed that with patience and careful training they could be taught to accept real responsibilities.

Admittedly, the program was launched with some misgivings because no one had ever before dared to use volunteers under 18 years of age to help with nursing duties, but that belief has been more than justified in the Jangos.

Army and Navy Daughters

The Jangos (Junior Army-Navy Guild Organization) are the daughters and young wives of officers in the armed forces organized to do worth-while work to aid the war effort. The hospital project is only one of their activities. They come to us after a preliminary interview with their own project adviser, who takes care of the details of outfitting them with a uniform.

The project adviser finds out what hours the Jango can give and then, consulting a list of hours given her by the hospital, assigns the volunteer. She also eliminates applicants not suitable for hospital work.

Jangos are divided into two groups, 14 to 16 and 16 and over. Members of the younger group are not allowed to work on the patients' floors, except occasionally to carry trays. For the most part, they serve at the information desk, answering queries and delivering flowers to patients, and they do filing in the record room and at the insurance desk. In the diet kitchen they help squeeze orange juice and answer the telephone.

The second group is made up of girls 16 and over who take classes three times a week. The course includes demonstration and practice in making beds, giving baths, hospital housekeeping and morning and evening care. To add interest we particularly stress nursing history and ethics. We are not a teaching hospital and have no classroom, so we use one side of the solarium screened off. Three beds are wheeled in, three Jangos act as patients, three as students and three as student teachers.

The head nurse cooperates with us in using discretion about the type of patients assigned to them and tells us the nursing staff could not carry on without the help of these girls.

One hundred fifty hours of instruction, practice and demonstration are given. Classes have at times had to be on a somewhat elastic schedule because of shortages of nurse instructors, but when a day would come when classes were not possible the volunteers cheerfully carried water pitchers and served trays. Each Jango in a class promises to return 200 hours' service to the hospital.

Have More Time Than Housewives

When the instruction period is over capping ceremonies are held. The caps and certificates are eagerly worked for by the girls and indicate to the nurse the scope of the individual Jango's activities. Rear Admiral Ross T. McIntire, the President's personal physician, gave the address to the March class.

One adviser is at the hospital each day to sign the girls in, inspect their

irls of the Junior Army-Navy Guild Organization (Jangos) do a sponsible volunteer job at Doctors Hospital, Washington, D. C.

ppearance and give advice. A record e is kept of each girl's training, ours, appearance and behavior.

The girls themselves are eager, illing and quick to learn. They do ot have the responsibilites of a ome that older women have so are ailable more often, sometimes giv- g practically all their spare time to e hospital. They give to their work e warmth and cheerful gaiety of outh and the hospital gives to them n opportunity for growth, a place o serve and a worth-while way to end leisure hours.

For many Jangos new fields have een opened. Several have entered hools of nursing and pre-medical urses.

To give more concrete evidences their worth, so far there have en two Jango classes, 60 girls in l, and of that number all except ur finished the course. Many of em have already completed the 0 hours promised.

During the attendant nurses' vacation period the Jangos supplied all the relief needed, some of them working full time. Although we paid these full-time Jangos, they would not have been available to us if we had not trained them as volunteers, and since many were going to college this fall it helped them, too. In June 137 Jangos gave 2430 hours; in July 142 gave 2813 hours; in August 95 gave 2338 hours.

The results have not been obtained overnight. It has taken more than a year of care and patient training, but it has been more than worth while.

Doctors Hospital believes the same sort of program could be developed with any group of responsible high school girls, provided they understood they would not be in any way connected with Jangos. We will be glad to furnish more specific information concerning the course of instruction to anyone interested.

SUGGESTIONS FOR JANGOS

DO remember that sick people are especially sensitive; little things upset them.

DO remember that your appearance is very important; that you must be in uniform and neat and tidy.

DO remember that your hair must be pinned up; if necessary, wear a net.

DO remember that you must not read charts or concern yourself with the patient's condition or family affairs.

DO learn the routine expected of you and go quietly about your work.

DO remember that the nurses will be glad to help you.

DO sit at the desk when you are not busy.

DO remember that we are glad to have you with us, even though we may seem busy and preoccupied.

DO read the Florence Nightingale Pledge and try to live up to its spirit in everything you do.

DON'T talk loudly or bang equipment around; be gentle and quiet.

DON'T wear long nails or bright nail polish; don't wear jewelry or perfume.

DON'T let your hair hang loose on your shoulders.

DON'T repeat to anyone anything that may come to your knowledge concerning either the patient's condition or family affairs, or discuss it among yourselves.

DON'T constantly ask the nurse what to do next. Try to notice when you can be helpful.

DON'T do for patients anything not in your routine without asking the nurse to advise you.

DON'T visit with other Jangos, the attendants, maids or nurses while you are on duty.

DON'T forget that this is an important vocation, caring for the sick.

4. *They're Life Savers* in Small Hospitals

NURSES' aides, both volunteer and paid, have been life savers to the small hospitals of America. This is the majority view of the 26 hospitals that replied to a questionnaire sent to 50 small hospitals.

All but one of these reporting hospitals use nurses' aides. Two use only paid aides, nine use only volunteers and 14 use both types.

For the paid aides, a surprisingly wide range of salaries is reported. One California hospital pays $115 plus one meal a day, while a Pennsylvania hospital pays only $30 per month plus one meal. If meals are valued at $10 per month each (which is probably too low a figure for the present food costs), room is valued at $10 per month and laundry at $5, the salaries can all be converted to a full cash basis. This was done for the 15 hospitals reporting and it was found that the pay ranged as follows: $40, one hospital; $57.50, one hospital; $65, two hospitals; $70 to $79, five hospitals; $80 to $89, four hospitals; 105, one hospital; $125, one hospital. The median salary, therefore, is about $77.

Of the 23 hospitals that use volunteer nurses' aides, 20 obtain them from the American Red Cross. One uses local home nursing course students and one reports the civilian defense committee as the source. Three of those that use Red Cross aides also have some from other agencies (Girl Scouts, women with some nursing education and O.C.D.).

The duties assigned to volunteer nurses' aides are, in general, those specified by the American Red Cross. There is a definite tendency to increase the duties of nurses' aides. Ten hospitals reported that they had increased the duties during the past year.

The two hospitals using only paid aides reported the following duties: dusting, bed making, carrying trays, giving evening care, care of flowers, cleaning units and medicine closets, giving bed baths, taking patients to and from surgery and x-ray departments, running errands and answering telephones.

In hospitals using volunteers or both paid and volunteer aides the duties seem to be more extensive. A 58 bed hospital at Bath, Me., reports the duties as "all except actual treatments."

The accompanying outline of the duties of ward aides was prepared by Nicholls Hospital, Peterborough, Ont. While it is the most complete list that was submitted by any hospital, there are some items mentioned by other hospitals that are not included. They are: writing letters for patients, making surgical supplies, acting as chaperon in special departments, collecting specimens (urine, feces, sputum, vomitus), draping patients for doctor's examination, preparing gavage trays, giving shampoos to bed and ambulatory patients, recording in notebook intake of liquids and output of urine and evacuations, taking and recording temperature, pulse and respiration, assisting patient in dressing and walking, sitting with patients coming out of ether, assisting nurse with new-born infants. One hospital reports that aides are not permitted to enter the isolation unit while another reports that they are instructed in the care of patients with communicable diseases.

One proof of the value that these small hospitals attach to the service of the nurses' aides is that an overwhelming number of them think that the use of nurses' aides will continue in small hospitals after the

DUTIES OF WARD AIDES
Nicholls Hospital
Peterborough, Ont.

ADMISSION OF PATIENTS

1. Give baths—tub and bed patients—children only, under supervision of graduate nurse.
2. List patients' clothes and deliver them to clothes room.

CARE OF PATIENTS

1. Assist nurse with care of ward patients in such matters as enemata, use of bedpan.
2. Assist nurse with care of involuntary and disturbed patients.
3. Transport patients to adjunct departments under instructions from nurse in charge.
4. Pass wash basins, soap, towels, mouth wash, drinking water and other similar services for adult patients.
5. Give morning and evening care to children.
6. Dietary: general care of trays and tray equipment; learn routine diets, and assist in serving; prepare nourishments served between meals to patients and serve; care for water jugs and give fresh water; prepare helpless patients for meals—place back rests, give diet towels; use of drinking tubes, feeding cups; feed infants—use of bottle, method of holding infant, expelling of gas.

DISCHARGE OF PATIENTS

1. Dress babies on discharge.
2. Dress adults on discharge.
3. Receive patients and accompany them to business office and door.
4. Assist nurses in the care of the dead.

MESSENGER

1. Take drug basket and prescriptions to dispensary. Care of drug basket.
2. Delivery of medicines, stock drugs to ward.
3. Obtain supplies from central service room and return carts, trays and unused supplies.
4. Obtain diets from milk laboratory.
5. Deliver diet requisitions to dietitian.
6. Deliver x-ray and laboratory requisitions to laboratory and x-ray department.

HOUSEKEEPING

1. Check supplies received from storeroom and put them in proper place.
2. Receive, check and put away clean linen.
3. Disinfect beds after discharge of patient. Strip bed, and remake, open, closed, anesthesia, ambulance and cot beds.
4. Care of screens, *i.e.* daily dusting, routine cleaning and changing of screen covers.
5. Dust ward, empty and clean waste-paper baskets, clean bedside tables daily and arrange equipment in proper order in and on tables. Clean beds and all other equipment, lights, windows and chairs daily.
6. Care for and arrange flowers, care for vases.
7. Clean various types of equipment: enamelware, all types, including routine and weekly care of bedpans, urinals, brushes and solution pails; glassware; rubber tubing, rubber gloves, hot water bottles, ice caps, ice collars, bed rubbers; instruments, oil instruments not in frequent use; needles.
8. Care for sterilizers; give routine daily care including addition of sodium bicarbonate.
9. Clean cupboards daily and weekly.

war. Sixteen said "yes" and only four said "no" to a question on this subject.

Of the 16, four specified that they were referring to paid nurses' aides and one to volunteer aides. The remaining 11 did not specify whether they meant the paid or the volunteer type. The negative votes include one that foresees the discontinuance of volunteer aides and three that did not specify.

The future of nurses' aides is conditional upon other factors in the opinion of six respondents. Two of them stated that it will depend upon the number of graduate nurses who are available; three believe that nurses' aides will continue to be used if there is no nursing school, and one suggests that the answer will depend upon the number of student nurses available.

The final question asked was: "What are the particular problems presented in the use of nurses' aides in small hospitals?"

Eight of the 25 hospitals reported that there were no particular problems. Several of these, as well as those that did report problems, mentioned a deep sense of gratitude for the assistance they have received from the aides.

"We have not had any trouble with our aides. They are told certain things that they cannot do and they have cooperated very nicely," reports Lillian M. Purcell of Massie Memorial Hospital, Paris, Ky. "I do not know what we would have done the past year without the Red Cross aides. We could not get graduate nurses," she adds.

Even more graphic evidence of the "life saving" value of aides is given by Ruth A. Wescott of Alameda Hospital, Alameda, Calif.

"At the present time, owing to insufficient number of trained nurses, supervision of aides is not nearly as close as it should be and attendants, particularly those without formal training, take on too great responsibilities. Also, the Red Cross aides complain that we do not teach them more, which is impossible because of insufficient number of charge nurses and the fact that those we do have are not trained for teaching.

"We have one floor containing 17 patients with only one charge nurse and attendants and another floor with 34 patients and two nurses and attendants. The responsibility and worry of the nurses are becoming almost too great. I cannot see any answer. Some aides are better than some nurses, although the number is few; these will always have a place in the hospital, I think."

"We have had so few problems with our aides," says Margaret Johnston of Beloit Municipal Hospital, Beloit, Wis. "I think it may have been due to the great care with which the members of the group were chosen. We had an excellent committee chairman."

A few doctors expressed some opposition to aides when the program was first started, says Edna G. Davidson of Black Hills General Hospital, Rapid City, S. D. "Now there are no problems and the doctors are well satisfied," she says. "This type of worker, both paid and volunteer, has filled a great need in the hospital. Our paid aides have ranged from girls in the last year of high school to those who have college degrees. We have trained them on the job after a short instruction period. They are well liked by patients, graduate nurses and doctors. We are grateful to them."

"We have had no trouble with our aides. They are a great help to us," reports Sister M. Albertine of Warner Brown Hospital, El Dorado, Ark.

"Relations with our aides have been very pleasant," is the succinct comment of Gertrude J. Buckles of Deaconess Hospital, Billings, Mont.

The following problems were mentioned most of them only by one hospital: professional ethics (preserving confidential character of information); irregular attendance and absenteeism; difficulty of getting and keeping aides; inability of hospital to provide adequate training and supervision; some aides not very adaptable; occasional absence because of home responsibilities; doctors and nurses expect too much of aides; compete with student nurses for experience; occasionally are not acceptable to private patients; refuse to work on certain days, and some friction between volunteer and paid aides.

One hospital that is now paying its aides $40 per month plus three meals and uniforms, with a six day week of eight hours per day, reports that its paid aides want more money. Since this hospital is in a war industry area, such a request is not surprising.

LIST OF REPORTING HOSPITALS (BY SIZE)

Using Both Volunteer and Paid Aides

HOSPITAL	PERSON REPORTING	CAPACITY
Elko General, Elko, Nev.	Malena Kelley	50
Massie Memorial, Paris, Ky.	Lillian M. Purcell	50
Black Hills General, Rapid City, S. D.	Edna G. Davidson	51
Bath Memorial, Bath, Me.	G. Wolstenholme	58
Valley View, Ada, Okla.	Ann C. McBride	65
Alameda, Alameda, Calif.	Ruth A. Wescott	92
Emergency, Annapolis, Md.	Mabel Merrick	97
Beloit Municipal, Beloit, Wis.	Margaret Johnston	100
Brownsville General, Brownsville, Pa.	Mrs. L. S. Knuth	100
Belmont Community, Chicago	Gertrude F. Scofield	100
Protestant, Nashville, Tenn.	Elizabeth Sloo	104
Nicholls, Peterborough, Ont.	John Hornal	114
Independence, Independence, Mo.	Gertrude E. Copeland	150
Baptist, Alexandria, La.	Isabella Coults	150

Using Only Volunteer Aides

Devils Lake General, Devils Lake, N. D.	Mildred Clark	50
Mennonite General, La Junta, Colo.	Maude Swartzendruker	50
West Hudson, Kearny, N. J.	Margaret I. Hunter	64
Warner Brown, El Dorado, Ark.	Sister M. Albertine	69
New Hampshire Memorial, Concord, N. H.	Bertha L. DeLong	91
Brewster, Jacksonville, Fla.	Florence M. Jones	95
Deaconess, Billings, Mont.	Gertrude J. Buckles	103
Amsterdam City, Amsterdam, N. Y.	Mildred Constantine	138
Warren A. Candler, Savannah, Ga.	Charles W. Curry	141

Using Paid Aides Only

Fred Roberts Memorial, Corpus Christi, Tex.	Mrs. Ed. R. Sizer Jr.	72
Victoria, Prince Albert, Sask.	H. Bassett	80

Using No Aides

Naeve, Albert Lea, Minn.	Mary King	90

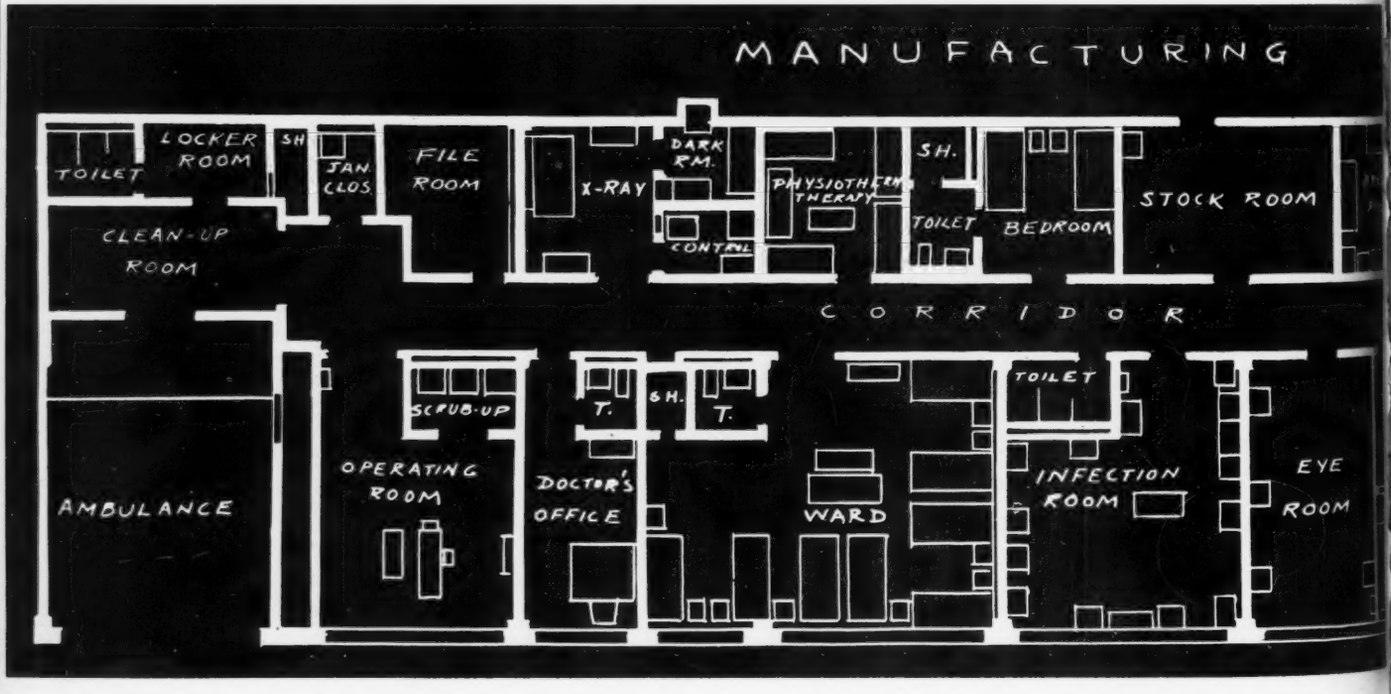
Designing Quarters for
of a Modern

Designed by ALBERT KAHN
Associated Architects and Engineers, Inc., Detroit

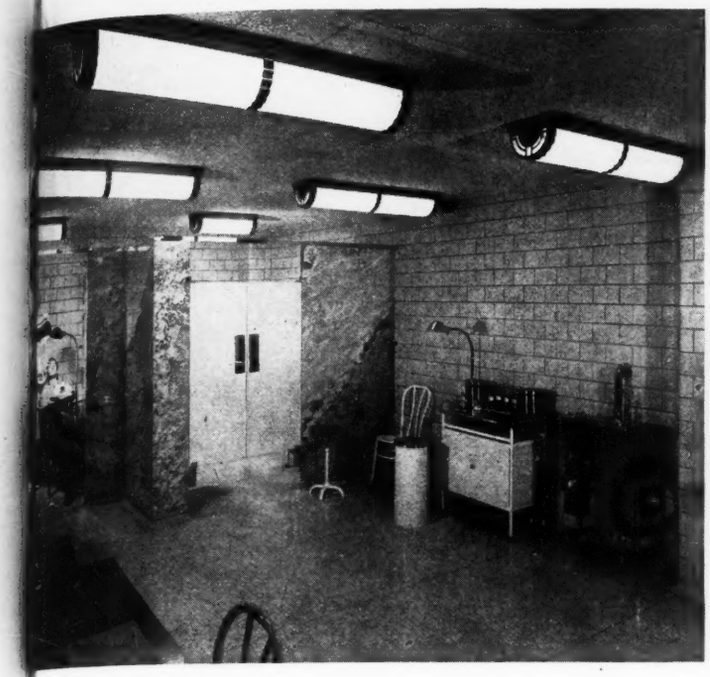
LOCATED on the ground floor of a two story office section of the Ford Bomber Plant at Willow Run, Mich., is this industrial hospital.

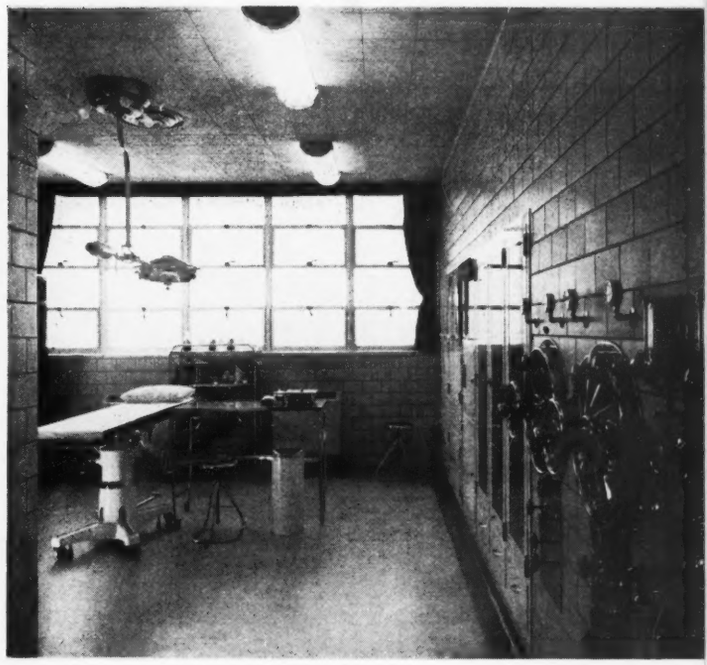
Seven doctors and 40 nurses supervise the staff of 100 for there are also first-aid men, industrial hygienists and various technicians and assistants. This number is not excessive for the hospital and first-aid rooms are operated on three shifts.

The hospital area is rectangular and is divided into 27 rooms, including an enclosed ambulance entrance and a clean-up room. Across one end is a nurses' rest room and across the other a women's ward.



Equipment for treatment and operating rooms, here shown, is complete in every respect and would be the envy of the administrator of the finest general hospital.





the Medical Services American Factory

In conjunction with representatives of the
FORD MOTOR COMPANY

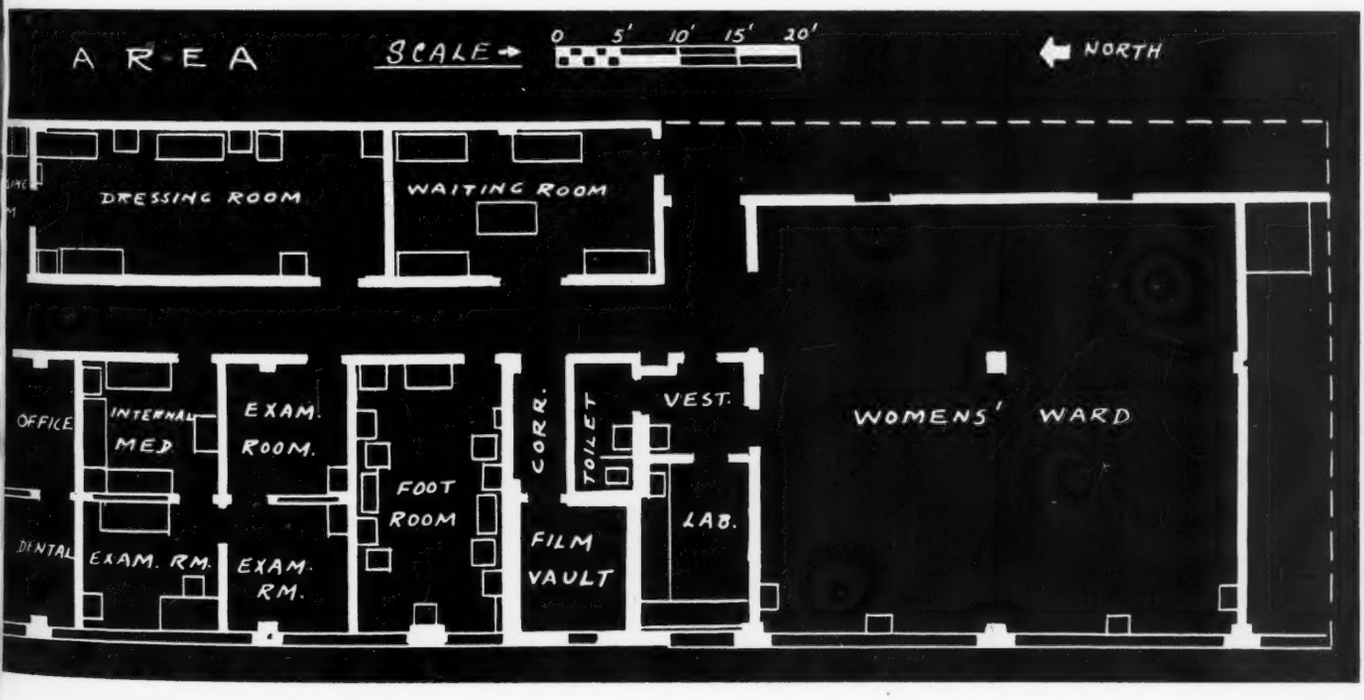
The men's ward contains seven beds and four cots, the latter being used chiefly for physical therapy and diathermy treatments. The women's ward has 10 beds. The beds are for temporary occupancy only, since all treatment is of an emergency or temporary character.

In addition to the hospital proper, which occupies an area of 180 by 40 feet, the Ford Bomber Plant has a large examination room in the personnel building and six first-aid rooms located at strategic points in the plant.

The hospital walls are of glazed ceramic tile; ceilings are of acoustical tile. Floors are terrazzo. The windows are of glareproof, heat-resisting opaque glass.

Lighting is of the fluorescent type. Heating is by radiators of the wall-hung convector type with sloping grilles in the top.

The entire area is air conditioned.



This is no time to Hoard Beds

ALFRED E. MAFFLY
Superintendent
Berkeley Hospital
Berkeley, Calif.

A HEAVY burden has been placed on hospital facilities in many of the war production areas in the United States because of the tremendous influx of war workers to these centers. Hospitals have increased their accommodations by placing two beds in most private rooms, adding more beds to wards and converting sun rooms, libraries and similar rooms for the use of bed patients. In spite of the many beds which have thus been added, it has still been necessary for hospitals to reject patients.

However, a hospital cannot well close its doors, merely because its facilities are all occupied, as a mercantile establishment might do when its stock of merchandise is exhausted. Hospitals recognize their responsibility to provide adequate care for all the sick and injured when they need it.

If voluntary hospitals do not properly discharge this obligation to see that all the sick in the community are provided for and that none is denied the medical and hospital care he needs, they must expect demands to be made for some other agency to provide such services. Rejection of patients by hospitals, because of limited facilities or other reasons, is bound to lead to further socialization of medicine and the establishment of more beds in government hospitals to take care of the rejected patients.

Although temporary population increases have overcrowded present hospital accommodations in many localities, every possible effort should be made by all voluntary hospitals to accept all patients who apply for aid.

Rejecting patients is certainly the easy way to solve the bed shortage problem, but the price of this short-sighted policy will be high in the long run. Better to use halls for additional patients than smugly to reject applicants for admission.

The shortage of beds is one of the most vital problems facing hospitals in certain areas today and is a real challenge to our entire voluntary system. If we fail in its solution, we strike a grievous wound deep into our public relations program and actually invite eventual ruin.

The shortage of hospital facilities has been particularly acute in the East Bay side of the San Francisco Bay area and has become a matter of great concern to both physicians and hospital administrators. A joint liaison committee consisting of three representatives of the Alameda County Medical Association and three representatives of the East Bay Hospital Conference was therefore appointed to study the problem and to make recommendations.

Investigation by the committee soon revealed that patients were being rejected by East Bay Hospitals, not merely because of shortage of hospital beds and hospital facilities, but also because of the shortage of nurses and trained hospital personnel. Most of the hospitals had been increasing their capacities by purchasing additional beds and bedside equipment and doubling up their facilities. There had been no particular difficulty experienced in purchasing equipment of this type.

An important problem has been the increasing shortage of manpower. Hospitals have frequently been obliged to cancel surgery and to reject bed patients, even though they had unfilled beds available, because of inadequate nursing care for the facilities they did have. Purchase of additional beds alone could solve but part of the problem.

The committee made several spot checks of hospital facilities and hospital occupancy. The following is a typical study taken of the nine approved hospitals at midnight on May 29, 1943. The census figures were taken at midnight, as this is the customary time of computation.

Of 1072 hospital beds available for private patients (not including bassinets for the new-born), 144 were empty at midnight of May 29. However, while it was true that many of these empty beds were filled the following noon and certain hospitals were completely filled to capacity by then and began to reject patients, other hospitals were not overloaded and could have taken care of patients rejected. Spot checks taken on five other typical days revealed similar results.

It became apparent to the committee that there was an unequal distribution of vacant beds among the hospitals. Some of the hospitals were full most of the time, some were full some of the time, but not all were full all the time.

Several hospitals were reserving their beds primarily for the use of their active staffs. In fact, some of them have made their beds available to their active staffs *exclusively,* even

Occupancy Statistics, Approved Private Hospitals in East Bay, May 29, 1943 11:59 P.M. (Midnight)

Hospital	*Total Capacity*	*Empty Adult Beds*	*Rejected Patients 5/21-5/27*	*Per Cent Occupancy*
Alameda Hospital	97	21	8	
Alta Bates Hospital	116	14	0	
Berkeley Hospital	90	23	0	
Childrens' Hospital	70	12	0	
East Oakland Hospital	80	12	1	
Merritt Hospital	178	11	42	
Peralta Hospital	160	14	12	
Providence Hospital	220	28	6	
Richmond Hospital	61	9	0	
	1072	144	69	86.5

Ways to Overcome the Shortage of Space and Service

Committee Recommendations for East Bay Area

1. There is no overwhelming shortage of hospital facilities in the East Bay. Present facilities are cramped and are being used to capacity but should be adequate to take care of the acutely ill and severely injured. If hospital facilities are used to maximum capacity, all luxury hospitalization is abolished, all patients are discharged from the hospital at the earliest possible time and complete cooperation is established between the doctors and hospitals, it should rarely be necessary to reject critically ill private patients.

2. Further reduction is possible in the average hospital stay of patients. Hospitalization of obstetrical cases has already been reduced from ten days to five in most hospitals.

Surgical and medical patient stays should similarly be reduced to 50 per cent of the usual time, if possible. The hospital stay of industrial cases should be greatly reduced.

3. Orthopedic and other convalescent patients should be sent home or transferred to convalescent homes as quickly as possible. A list of convalescent homes should be prepared and distributed to doctors and hospitals.

4. Facilities for the rental of bedside equipment should be investigated so that more hospital equipment might be made available to encourage some of the less acutely ill patients to set up their own hospital facilities at home.

5. Arrangements should be made with the Visiting Nurses' Association for more bedside care at home.

6. Luxury nursing and luxury hospital service should be abolished for the duration. Hospital and nursing care should be requested on the basis of medical need only, not merely because of financial ability to pay.

7. Special duty nursing should be minimized to assure more efficient distribution of the available nursing care. Special nursing should be limited to the extremely sick and for medical reasons only. Special nurses should not be assigned to a single patient but should take care of two, three or even four patients at one time.

8. Registered nurses now employed in doctors' offices should be encouraged to accept general staff duty, and doctors should be urged to employ competent medical secretaries rather than registered nurses whenever possible.

9. Retired and inactive nurses should be encouraged to enroll in refresher courses and return to the field of general duty nursing on either a full-time or a part-time basis as part of the Victory Nurse Program.

10. Hospitals should make full use of volunteers. Red Cross nurses' aides should be used more extensively in hospitals to relieve nurses. The committee found that hospitals had not used volunteers to maximum capacity in their various departments; 743 nurses' aides have been graduated by the Red Cross in Oakland and Berkeley.

Each hospital should set up a weekly program stating the number of aides desired, preferably by regular four hour periods each week. The Red Cross already had many more nurses' aides available than the hospitals have been willing to absorb. When they are sent to the hospital, **the aides should be used for real work and not just tolerated.**

11. Hospitals should take advantage of victory worker campaigns being conducted by local manpower committees. Many victory workers are available for part-time service in hospitals after they have completed their home tasks or their regular day's work in other occupations.

12. Hospital staffs should not hoard beds for their active staff members. Empty beds should be made available to all members of the Alameda County Medical Association for the duration. Doctors should become active staff members in more than one hospital, so that they will have more beds available for their patients.

13. If the present pressure for hospital facilities becomes more acute, it is recommended that a central clearing agency be set up for more effectual use of vacant beds. The Alameda County Medical Association or the East Bay Hospital Conference could maintain such a clearing house in its secretarial offices. One clerk could be detailed to telephone each of the nine hospitals every morning to determine the number of empty beds available.

When a physician cannot be accommodated by the hospital of which he is an active staff member, he could be aided by the central clearing agency, which might be able to assist him to procure accommodations in another hospital that happened to have vacant beds at that time. This plan would require the cooperation of all hospital staffs and their willingness to make their empty beds available to all members of the Alameda County Medical Association.

though there were empty beds that might have been used by staff members of other hospitals which were filled to capacity at the time. It would seem that such "hoarding" of our limited hospital beds is certainly contraindicated in these trying times.

On the basis of its investigation the committee made the recommendations shown on the preceding page.

The committee was convinced that present hospital facilities were adequate to take care of those who urgently need hospital care, provided that doctor, hospital and patients are willing to cooperate for the duration in eliminating luxury services and are willing to ration hospital facilities for the benefit of the severely ill in the most efficient manner, and provided, too, that both doctors and hospitals realize the serious consequences of the rejection of patients and are willing to make every effort to provide hospital care for all who need it.

These Dolls Work for the Hospital

NELLIE GORGAS

Superintendent
St. Barnabas Hospital
Minneapolis

ONE of the projects undertaken by the students at St. Barnabas Hospital, Minneapolis, about two years ago as a part of their training program has proved of such value to the hospital and school from various angles that it might be of considerable interest to other hospital administrators fortunate enough to have schools of nursing in their organizations.

The instructor of the nursing arts class, Ethel Williams, assigned to each student the task of dressing a doll in the costume typical of some particular phase in the history of nursing.

The girls bought their own dolls — all of uniform height — but with quite different features. They read history and studied their subjects carefully with rather amazing results.

As may be seen from the accompanying picture of the 39 dolls now in the collection as a result of the work of several classes, the expression and attitude of each doll are quite different and are well suited to the period and type of nurse portrayed. The collection, arranged chronologically, begins with the cave woman who, after all, was the first nurse for, surely, she had to care for her family.

The goddess Hygeia, the religious orders, Sairey Gamp, Florence Nightingale and the last fifty years of graduate and student nursing uniforms are included. The most recent divisions in the nursing field are represented by the dolls in the top row, the Army and Navy nurses, the Red Cross nurse, nurses' aide, Gray Lady and canteen workers.

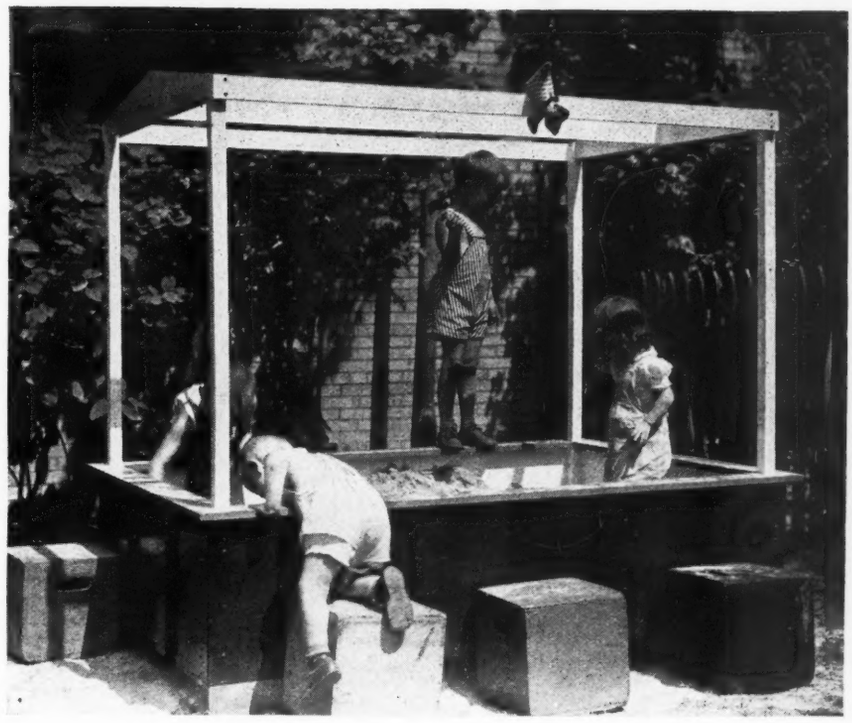
The collection is admired by patients and relatives, salesmen and friends who see parts of it always in the display cabinet at the front elevator. But the real value lies in the teaching material it provides and the foundation it forms for many talks to clubs and groups that are interested in the hospital.

By special request the whole collection has formed the nucleus of talks to many church groups that might be interested in sending girls into training or women into the volunteer army so badly needed in the hospital today — the Red Cross workers or civilian defense helpers.

The League of the Hard of Hearing, the federation of women's clubs, girl scout groups and business and professional women's clubs are more easily told of the hospital's objectives and progress and problems when these dolls are used to enlist their interest.

Even prominent department stores and other commercial concerns, such as the telephone company, have borrowed the dolls for display in their windows during Red Cross or Community Fund drives and have been appreciative of the opportunity.

The girls and the volunteers in the hospital have been so proud of the reception of their efforts that they have gladly cooperated in keeping the collection in condition by washing and ironing the costumes. It's a great deal of fun for all concerned and has proved to be well worth the time involved.



To attract married nurses we opened a

DAY NURSERY

PEARL PAGE PEABODY

University Hospitals of Cleveland

SOON after the United States entered the war, it became apparent that there would be a shortage of nurses with whom to staff civilian hospitals.

The nursing council of University Hospitals, Cleveland, after studying the problem, realized that one of the best sources from which to draw would be the unemployed married nurses. Many of these women would be glad to work, at least part time, except for the difficulty of obtaining adequate help for the care of their children; thus it was that in April 1942 the suggestion was made that the hospital open a day nursery. The idea percolated until summer and, finally, in August the nursery was organized.

An unused division of the Babies' and Children's Hospital seemed to be the logical location for the project; consequently, it came under the jurisdiction of the nursing supervisor of that service. It was decided that children from infancy to 5 years of age would be cared for, Monday through Saturday, between the hours of 8:30 a.m. and 5 p.m. Enrollment was to be restricted to children of nurses; a graduate nurse was hired to care for the children. After due inspection and licensing by the city, the nursery was opened on August 11 with an enrollment of one infant. It was opened in spite of this enrollment on the theory that a project already under way would attract more attention than one confined to paper.

This theory was proved to be correct for, with the cooperation of the newspapers in putting the idea across, within one month the census was increased to nine children making available to the hospital 222 nursing hours during one week. This figure has continued to increase each month.

At the end of the first month it became necessary for the nurse in charge of the nursery to resign. Her position was filled by a woman with experience in caring for children. She was assisted by volunteer workers, also chosen for their training and experience. This plan made it possible for the nursery to be open seven days a week from 7:30 a.m. to 5 p.m. and thus help the staffing problem on Sunday.

The hospital has made no attempt to calculate the cost per child of this nursery because of the inaccuracy of estimating the value of so much that was already available. The expense is accepted as a war-time emergency and is absorbed entirely by the hospital with no cost to the mother.

For a project of this kind to be successful, the needs of the mother and child as well as those of the hospital must be considered.

In order to relieve the mother of as much home responsibility as possible, her child may be dressed in hospital clothes. The infant may also be bathed during the day if the mother wishes. He is placed on the same schedule as the mother has for him at home and the food and formula are prepared and furnished by the hospital. For the infant on breast feedings, the mother is given time off duty to nurse him.

On the child's first day, he is given a complete physical examination by a staff pediatrician. The children's temperatures are checked daily and they are examined by the pediatrician for skin, nose and throat infections. Children with minor illnesses are not sent home but are isolated, thus allowing the mothers to finish their work for that day. Adequate isolation of these children is possible for, as the division was originally set up for sick children, the beds are all separated in cubicles. One room has also been set aside on one of the sick divisions for infectious cases.

As well as his physical needs, the child's training and social development are considered. He is taught routine habits of regularity and cleanliness. Individual attention is given

Other day nurseries couldn't solve our problem because they do not accept children under 2 years old. So ours will continue for the duration.

the child as he reaches new stages in his development, such as walking, talking, feeding and learning to dress himself.

The child's social progress is taking place at all times because of his constant contact with the other children; however, this aspect is stressed in the giving of parties for birthdays and special occasions. The improvement in party conduct over a six month period has been remarkable for such young children.

How Nursery Has Helped

The mothers are all anxious to do what they can during this emergency. In some instances the income is the most important factor; in others, where the husband is in the armed forces, it keeps the nurse-mother occupied and helps her to feel that she, too, is doing her part. These mothers contribute with the assurance that their children are well cared for.

The degree to which the nursery has helped the staffing problem can best be shown by conclusions drawn from available statistics.

1. There is a turnover of nurses making use of the nursery, but it is in the group of nurses working part time.

2. There is a tendency in this part-time group to work more hours per week.

3. Since the time the nursery was organized, all the mothers working forty hours per week or over have remained.

4. With the same number of nurses working in March as in September, the nursing hours made available to the hospital through this channel have increased fifty hours per week.

The nursery undoubtedly will be continued for the duration. Other existing day nurseries cannot help our problem because they do not accept children under 2 years of age. In the entire turnover of enrollment since the organization of the hospital nursery, there have been only three children who could have fulfilled the age requirement. Difficult transportation facilities would in most instances make the use of a public day nursery impractical, so the apparent conclusion is that by far the majority of these mothers could not work at their profession if it were not for the existence of our nursery.

Does Not Solve Entire Problem

It is not a solution, however, to all of the nursing problems. A nurse with a family places her home responsibilities first. If her child is ill, she cannot work; therefore, her help is not altogether dependable. These nurse-mothers must also work days because of the limited hours the nursery is open. It may be necessary to have the nursery open longer hours.

The nursery has also presented its own problems. Originally planned for the care of sick children, the division will again be used for that purpose. Because of the temporary nature of the project, changes in construction that would greatly aid in the care of the well child are impractical to make.

One of these difficulties is inadequate toilet and lavatory facilities. Taking a child to the toilet necessitates leaving the division and going to another floor. This problem has been met, in part, by the purchase of nursery chairs, but they are hardly adequate for the 4 and 5 year olds. The sinks are at an adult height and are controlled by a foot pedal so that a child must be helped every time he washes. Both of these conditions involve considerable waste of time of the limited number of helpers available.

The fact that the children sleep and play in the same room was another handicap. Most of the time there was a child sleeping so that the play of the others had to be confined to a small section of the room. There is a large enclosed porch off the room that would be ideal for playing; however, it could not be utilized because of the excessive noise made by the children. The problem has been beautifully solved by an outdoor play yard recently built.

Play Director Hired

Still another handicap was the lack of play equipment. Toys and books for sedentary play were plentiful, but children of these ages need more play equipment for excercise and physical development, such as tricycles, skooters, wagons and skates. The nursery supply was limited due to difficulty in obtaining this equipment. Recently we have acquired three tricycles and a scooter, which have helped the entertainment situation remarkably.

The acquiring of personnel to staff the nursery presents another problem. The volunteers are excellent but each works only a few hours a week, which means that it is difficult for each volunteer to adjust completely, both to the children and to the routine of the nursery. In order to solve this problem a full-time play director has been hired to help direct the children's activities.

We have obligations, social and scientific, toward our

Friends *to the South*

AUGUST KOENIG

AS A hospital worker recently returned from South America, I have been asked many times what part the North American hospital can play in advancing inter-American friendship.

This is a question that indicates that people here are awake to the need of better acquaintance with the other republics of this hemisphere. Of course, the hospital man who puts the question is fully aware of the magnificent contributions to the improvement of Latin-American health conditions made by the Rockefeller Foundation, the Pan American Sanitary Bureau and other organizations. What he really wants to know is how he and his hospital can aid in bringing about closer relationships.

When Opportunity Walks In

Many times this opportunity walks into a hospital in the person of a Latin-American visitor come to study our hospital organization and management and, perhaps, also institutional medicine. We naturally want him to go back to his country with an enthusiastic report about the progress of our hospitals and medical centers. We want him to be inspired to help build ideas gleaned here into better hospital service in his own country.

The fact that our North American hospitals hold a position of world leadership puts us under obligation to act as teachers and to give assistance to nations of this hemisphere; we find that in this process we can, in turn, learn much from our Latin-American friends.

Let us, then, endeavor to know our visitor a little better before we take him through our hospital. He may be a hospital administrator but being a physician, as required by custom and sometimes by law, he is also interested in medicine and in public health, and his training may have been more extensive in the latter than in the former. Until the last decade, higher education in his country has been chiefly a privilege belonging to the old and wealthy families and our visitor's education has been carefully planned and is comprehensive.

The Latin American's cultural background is European and he is linked to his ancestral homeland by strong sentiment in which politics plays no part but in which ties of religion, mode of living and education count for much. He admires our accomplishments, especially our widely famed efficiency, and is impressed by our cathedrals of learning but at the same time is convinced that we are interested only in material success and do not know how to practice the art of living while in the process of making a living. However that may be, the fact remains that Latin-American leaders, in spite of their close ties with Europe, frequently show themselves surprisingly well informed about us.

When such a visitor enters our portals, let us analyze his hospital background and discuss with him what he really wants to see. Take him on a quick round trip and then let him devote the rest of his time to a particular department of which you are especially proud.

Turn him over to the department head for a day or two and have him observe or, better yet, take part in the procedure step by step. Then, before he leaves your institution, review with him what he has seen. Let him ask you questions, and don't neglect to ask him for his ideas, too; he may have some interesting suggestions for you.

Don't put too much emphasis on the frills and gadgets you have developed, especially if they are complicated and expensive. Our Latin-American friends have a tendency to attach much importance to the unusual and spectacular, often at the cost of neglecting fundamentals and matters of routine. But they are eager to study at first hand the organization of our United States hospitals in order to learn how to make their own systems more efficient and stable.

Let us attract not only hospital executives but also other staff members of all ranks. We can offer student nurses, interns and other hospital workers from the other American republics more intensive and specialized training than they could receive in their own countries. Then after their visits are over we shall want to keep in touch with these new friends; the bonds thus formed should be lasting, both for personal benefit and for the good of our profession. Particularly will it be necessary for us to welcome their further inquiries and give them pointers from our experience to help them meet the problems that will arise as they attempt to apply in their own lands ideas gathered here.

We Receive as We Give

We shall find these hospital workers alert to promote social justice, to reduce poverty and to improve the living conditions of the masses of their people. Their enthusiasm in these respects is admirable, but from the point of view of the seasoned North American administrator it may seem that they are sometimes in danger of duplicating the work of other agencies in these fields and not giving sufficient attention to the details of administration which are essential when it comes to putting ideals into practice. At any rate, we can counsel with them on such questions, probably to our mutual benefit.

We shall have opportunities to extend generous cooperation to Latin-American universities and hospitals in the exchange of students, teachers and consultants and in organizing

study trips and institutes. We can prepare publications in Spanish and Portuguese to send south. We can make available to our own hospital workers information on the Latin-American hospital, enabling them to become acquainted with the work of such great sanitarians as Oswaldo Cruz, Carlos Finlay, Carlos Chagas and Carrion.

We can offer facilities for special research to the Latin-American seeker. Above all, it is important for us to give all aid and assistance to the Inter-American Hospital Association, the ideal clearing house for the disseminating of information along these lines. Although at present, war-time travel restrictions and pressing problems here at home prevent our taking trips of investigation among our southern neighbors, we may well plan postwar tours. Interest in the work of the Inter-American Hospital Association will open the way to contacts that will make such a trip pleasant and valuable. By way of preparation, you will find it worth while to read books on Latin America that will introduce to you a charming people with a fascinating history. True, you may pick up many ideas that you shall later need to correct. You will probably read many historical and ethnological discussions of why Latin Americans are different from us, only to find upon becoming acquainted with them that they are not so different after all.

The North American generally feels that his Latin-American friends neglect the practical side of life. We must remember that their countries are not so highly industrialized as is ours, business opportunities there have not been numerous and many members of well-to-do families have been more inclined to devote themselves to Plato than to finance. Their poets are more numerous than their economists and the general trend of thought has been affected accordingly.

Don't Crow Over Our Laws

When the hospital administrator with whom you have a letter acquaintance calls on you and you sit down for a chat with him, one of the first questions he is likely to ask you will be one about the progress of social legislation in the United States. Give him any pamphlets of interest in this connection that you may have with you—he will study them closely—but please don't tell him to pattern his procedure after ours. The Scot's prayer, "Lord, gie's a guid conceit o' 'oorselves," has never been voiced in Latin America, that attitude of mind being taken for granted; whence spring an unlimited capacity for praise and a marked dislike of criticism, however friendly and well intentioned it may be.

Besides, much of the social legislation now in force there is more advanced than corresponding legislation in the United States. Their social insurance laws predate those of our country and include sickness and disability insurance, hospitalization and medical care, protection in cases of industrial accidents and occupational disease, and pharmaceutical, prosthetic and orthopedic services. Insured employed women receive prenatal, obstetrical and postnatal care, with partial pay during a fixed period before and after childbirth.

The visitor will be interested in the fact that most Latin-American hospitals are government owned and operated, a result of the lack of civic organization there, which has fostered dependence on the central government.

The extent of the health problems of these countries is best indicated by the fact that in some of them public health appropriations have totaled as high as 50 per cent of the national budget; in the United States, on the other hand, the corresponding amount is a fraction of 1 per cent.

A.H.A. CONSERVATION POSTER

The average life expectancy in Latin America is about thirty-six years. The average stay in hospitals is roughly twice as long as in the United States.

Devastating, debilitating diseases of the tropics and semitropics, virulent fevers and fungus diseases account for it. While men move in a leisurely fashion under the climatic conditions found there, all microorganisms move, work and propagate rapidly. The problems are serious, but they are being met with intelligence and skill. The men in the leading hospital and health posts are as able and resourceful a group as we have here, as I well know from experience with them.

Long-Term Good Neighbors

Plainly, the health conditions of Latin America concern us, and health conditions here concern our southern neighbors. In a world shrinking at an extraordinary pace intra-hemisphere contacts are multiplying and will continue to multiply during and after the war, making us more and more dependent on each other. The present good neighbor policy of the United States is not based merely on our needs of the moment but represents a common-sense long-term view of relations with the other American republics.

It is true that the postwar period, with easy transportation facilities binding us together, will also bring strains to test our neighborliness. The Latin Americans anticipate this and are not too sure that our good will is the kind to endure.

Many of them consider that our present efforts to draw nearer to them spring from a formula adopted at Washington rather than from spontaneous feeling of the American people at large. We are eager to import goods from them now; will we always continue to do so in the face of changing economic conditions? And then, on the other hand, we have our questions about what will happen when the European salesman returns to South America.

We cannot forget, however, that the war we are engaged in fighting to preserve liberty, progress and the human virtues dear to us has brought the Americas closer together and shown us that we need to link our interests so far as possible. Let it be the concern of each one of us that we shall not drift apart again.

You Don't Have to Shout!

Helping the Deafened Patient Presents a Challenge to the Skill of the Nurse

GERTRUDE TORREY
Chicago

IT IS estimated that about 10 per cent of our adult population[1] and from 4 to 5 per cent of our school children[2] have defective hearing. This means that at any time a nurse may have a patient who not only needs the best possible physical care but who also challenges her skill by presenting many psychological problems resulting from deafness.

Otologists predict much loss of hearing among men at present in our armed forces so it seems probable that there will be even more deafened patients in the future than there are now. Shall we consider briefly the special care needed by these patients?

If a patient is not adjusted to deafness he may feel apprehensive and insecure and may also be extremely sensitive. The nurse's major objective will be to establish a reaction of security and comfort through sympathetic understanding and cooperation. The correct approach may change an unhappy patient into a happy and contented one and make the services of the nurse indispensable to the case. The changed attitude of the patient will be of great help to the nurse in giving routine care.

A few suggestions on working with deafened patients may be helpful. The deafened may be classified into four groups: (1) lip readers; (2) those who use hearing aids; (3) those who combine lip reading and the use of hearing aids, and (4) those who neither read the lips nor use a hearing aid.

The first thing to do is to ascertain in which group a patient belongs, then to adopt the proper technic and *follow* it. This does not mean to follow it sometimes and forget it the rest of the time but to follow it in all contacts with the patient.

- When a patient reads the lips but does not use a hearing aid, *never* speak until you have attracted his attention and you know that he is watching you. A light touch or movement of the hand will tell him that you are going to speak and will save you needless repetition.
- Do not speak when you are behind your patient. Always stand where you can easily be seen.
- Do not walk around while you are talking.
- Speak naturally and not too rapidly. Use a complete sentence and do not say just one word at a time. Keep a pencil and paper at hand and write clue words when necessary.
- Try to have the light on your face. Do not stand with your back to a window or a light, for your face will be in a shadow.
- Do not talk too much. Lip reading requires great concentration.
- When a patient uses a hearing aid always have it within his reach but arranged in such a way that it cannot be knocked off the table or bed. Always wait until the patient has adjusted the ear-piece or oscillator before speaking. Some patients may be able to hear quite normally with the hearing aid but the majority will understand better if they can watch

[1]National Health Survey, 1935-36. U. S. Public Health Service.
[2]Report of the White House Conference on Child Health and Protection. 1930.

←——Figure 1. Do not speak when you are standing behind the patient. Let him see your face.

Figure 2. ——→ Do not stand with your back to the window because your face will be in the shadow.

your lips also; in these cases follow the suggestions given for lip readers. Speak when you are not too far from the microphone and use as low a voice as possible.

• Some patients may neither read the lips nor use an aid. In such cases find out at once just how loudly it is necessary to speak and only speak when close to the patient; in cases of extreme deafness always speak close to the ear. This will save much wear and tear on both patient and nurse.

• Never laugh at mistakes. Do not be impatient. Do not speak any louder than may be necessary to meet the situation and do not repeat the same thing over and over when it is not understood. Say the same thing in different words or write a clue word.

These suggestions apply to patients who are ill but who are also deafened. A patient who is an ear case with resulting deafness or one whose illness has left sudden deafness presents other problems for the nurse to solve. Her responsibility is great, for she must meet the shock of realization of deafness and give help when the psychological aspects of the case may be far greater than the physical.

The nurse should be able to tell the patient what lip reading can do for him and how it has helped countless others. She should be able to tell a little about how it is taught. If the patient has residual hearing, she should tell of the great help given by hearing aids and should know something about their cost and where they can be obtained. She should tell of the free vocational advice, training and placement service given by state boards of vocational rehabilitation.

All patients should be referred to the American Society for the Hard of Hearing, 1537 Thirty-Fifth Street N.W., Washington, D. C., for free information on local hearing aid service, lip reading instruction and local chapters of the national organization. There are at present 165 organizations in the United States offering many forms of service to the deafened.

Before the patient has left her charge, the nurse should have started him on his way toward satisfactory adjustment to deafness and should be sure that he knows how to go on and help himself.

Great Britain Turns to Teamwork

CHARLES HILL, M.D.

Deputy Secretary, British Medical Association

SHOULD the government provide a complete medical service? If so, should every member of the community be entitled to avail himself of that service? Should doctors be salaried servants of the government?

The foregoing are some of the questions that have been agitating the minds of doctors and laymen in Britain in recent months.

The doctors have published proposals for postwar reorganization which are nothing if not comprehensive. Here is their definition of what the objects of Britain's medical service should be:

1. To provide a system of medical service that will achieve positive health, prevent disease and relieve sickness.

2. To make available to every individual all necessary medical services, both general and specialist, domiciliary and institutional.

Doctors are unanimous in the opinion that the new service should be enjoyed by 90 per cent of the community. At a recent meeting of the British Medical Association the debate centered on whether the remaining 10 per cent, the wealthier section of the community, should also be entitled to such a nationally organized service *as a right.*

By 94 votes to 92 the association agreed that everyone, rich and poor, should be entitled to avail himself, as a right, of the benefits of the proposed national medical services.

At present, Britain's medical services, though substantial, are provided by a number of different agencies, governmental and voluntary, with gaps in some places and overlapping in others.

The country's hospital service is provided by voluntary hospitals of great antiquity and high tradition and by governmental hospitals which, in recent years, have grown rapidly in scope and efficiency.

For mothers, infants and school children there exists an extensive health service administered by locally elected bodies.

The doctors' proposals envisage the consolidation of all existing government services into a national service, the coordination with it of the many voluntary agencies in the health field and all necessary additions to make the national service complete. The service would be administered centrally by a corporate body or department responsible to the Minister of Health. Locally, it would be administered by a democratically elected local body.

The focus of the new service is to be the health center. In every town and city one or more of these centers will be established, at which the general practitioners of the area will work. The doctor's house will no longer be his office. Doctors will work not as individuals but as members of a team, each team including nurses, pharmacists, radiographers and masseurs.

Behind these primary centers will stand special centers dealing with such conditions as tuberculosis or venereal and mental diseases. Associated with groups of centers, primary and specialist, will be the hospitals of the area, where the services of the specialist will be available.

The era of the individualist in medical practice is going. The single-handed doctor, armed with his limited resources, must give way to a team of doctors, backed by the resources of the nation.

Each patient will be free to choose his own doctor from those available at the local health center. To this the doctors attach exceptional importance. Mutual confidence between doctor and patient depends, they maintain, on the freest choice and the unfettered right of patient to reject doctor and doctor, patient. Such free choice can obtain even within a national service organized by the government.

A national service, however, does not necessarily mean whole-time government salaried service with the doctor as a civil servant. Indeed, the majority of doctors is strongly opposed to such organization.

About People

Administrators

Rev. John G. Martin, superintendent of the Hospital of St. Barnabas and for Women and Children, Newark, N. J., and **Eva E. Caddy,** director of nurses for the institution, were recently honored at a tea given by the auxiliary, the guild, the junior guild and the trustees of the hospital in recognition of their twenty years of service.

Mr. Martin, who is president of the American Protestant Hospital Association, has also served as president and executive secretary of the New Jersey Hospital Association.

Miss Caddy's activities in professional organizations of the nursing field include serving as president of the Hudson Valley League of Nursing, the

Otsego County Nursing Association, New York, District 1 of the New Jersey State Nurses' Association and the New Jersey State League of Nursing Education.

Dr. Frank R. Bradley, administrator of Barnes Hospital, St. Louis, and **J. Wesley McAfee,** president of Union Electric Company, have been elected trustees of Group Hosptial Service in St. Louis.

Sister M. Huberta, R.N., of the Sisters of St. Francis, superintendent and Superior of Mercy Hospital, Auburn, N. Y., has been transferred to St. James Hospital, Newark, N. J., as superintendent and Superior.

Rahno M. Beamish, assistant superintendent of nurses at Toronto Western Hospital, Toronto, Ont., is the new superintendent of Memorial Hospital, St. Thomas, Ont.

Mrs. Alma Stuive Reiter, superintendent of Community Hospital, Beloit, Kan., has been granted a leave of absence to join her husband who is serving in the armed forces.

Sister Mary Anne was recently appointed administrator of St. Anthony's Hospital, Dodge City, Kan., succeeding **Sister M. Gertrude,** who now becomes associated with the operating personnel of St. Joseph's Hospital and Sanatorium, Del Norte, Colo.

Sister M. Oswaldina, a member of the staff of St. Francis Hospital, Wichita, Kan., since 1928, has been appointed Superior of the hospital for a term of three years.

Department Heads

Hulda C. Fleer, formerly administrator of Aultman Hospital, Canton, Ohio, is the new personnel officer and director of volunteers at Evangelical Hospital, Chicago.

Kathryn S. Walsh has assumed the duties of director of volunteer service at Wesley Memorial Hospital, Chicago. She was formerly supervisor of volunteer service at University Hospital, Ann Arbor, Mich.

Charlotte Dowler has been appointed superintendent of nurses at King County Hospital, Seattle, Wash. She succeeds **Harriet Smith,** whose resignation was reported last month.

Mrs. Myrtle F. Langel of Lynchburg General Hospital, Lynchburg, Va., is the new record librarian at Virginia Baptist Hospital in that city. She succeeds **Mrs. Hazel B. Basham,** who has resigned.

Mrs. Anne S. Wood has assumed the duties of instructor of nurses at Virginia Baptist Hospital, Lynchburg, replacing **Eleanor Howey,** who has resigned. A graduate of the University of Virginia, Mrs. Wood was formerly instructor of nurses at Methodist Hospital, Philadelphia.

Sister M. Magdalene, who has been superintendent of nurses at St. Catherine's Hospital, Garden City, Kan., for seven years, is now taking a course leading to a bachelor's degree in nursing education at St. Mary's College, Leavenworth, Kan. **Sister M. Germaine** has been appointed to fill the position of superintendent of nurses.

Sister M. Silveria, R.N., has been appointed director of the school of nursing at Wichita Hospital, Wichita, Kan. She succeeds **Sister M. Carmel,** who has held the position for the last seven years. Sister M. Carmel has joined the nursing staff of Halstead Hospital, Halstead, Kan.

Isabella N. Williams has recently become purchasing agent at Michael Reese Hospital, Chicago. Miss Williams formerly held a similar position at Sinai Hospital, Baltimore.

Deaths

Paule B. Soule, assistant director in charge of the hospital department of Michigan Hospital Service, died suddenly of a heart condition. Not yet 40 years of age, Mr. Soule had served with the Michigan Hospital Service for two years. A few days before his illness he had arranged to accept a position on the administrative staff of the University Hospitals of Cleveland.

Dr. J. Rollin French, former owner of Golden State Hospital, Los Angeles, and past president of the Association of Western Hospitals, died recently.

S. Frank Roach, laundry superintendent of Jersey City Medical Center, Jersey City, N. J., died recently at the age of 71.

Miscellaneous

Dr. J. B. Looper is the new dean of the medical school at the University of Mississippi, succeeding **Dr. B. S. Guyton,** who resigned to devote full time to private practice.

Capt. Louis Roddis of the U. S. Navy Medical Corps has been awarded the Sir Henry Wellcome Medal and a $500 cash award for the year 1943, according to a recent announcement from the Navy Department. This is the fourth successive year that a member of the Naval Medical Corps has won this award, which is bestowed by the Association of Military Surgeons for an outstanding medical paper.

There is room for improvement in our

Mental Disease Hospitals

Facts and figures on these public hospitals — what to do about them

ROBERT WOODMAN, M.D.

Consultant on Mental Hospital Services
National Committee for Mental Hygiene, New York City

MENTAL hospitals are having a hard time. Their doctors have gone to war. Many of their nurses have been called to the colors and many of their attendants have been drafted or have volunteered. Still others have been lured away by industry and higher wages—higher than the wages of those who care for the mentally ill ever have been or are ever likely to be. These hospitals are receiving none of the voluntary services that general hospitals are getting. Their food supplies are expensive and difficult to obtain. There is danger that the standards of care of mental patients, built up over many years, may be impaired.

It is encouraging that the United States Public Health Service has this problem in mind. It has published during the past winter "A Study of the Public Mental Hospitals of the United States," based on the year 1938. This study shows that even before the present emergency and preoccupation with getting on with the war, much remained to be done before the care received by the mentally ill in many public institutions deserved the name of hospital care.

$1 a Day Is Too Little

No other group of hospitals is expected to be conducted at a cost of $1 a day. Yet in 1938, the cost per capita exceeded that figure in only four states: New York, New Jersey, New Hampshire and Massachusetts, and in the District of Columbia. In four other states, Virginia, North Carolina, Kentucky and Oregon, the per capita cost was less than 50 cents a day.

It must be apparent that wages for employes in all grades of work, meals for patients and employes, clothing, fuel, light and water, upkeep and repairs just cannot be adequately met at 50 cents a day. To make matters worse, there are places where the needs of the mentally sick are prostituted to private selfishness, accompanied by political domination of appointments and purchases.

The best institutions well deserve the name of hospitals. They have qualified medical superintendents and staff members who are well educated in their specialty, who have been appointed for their qualifications only, who are in touch with the medical life of their communities and with research in psychiatry and who are alert to the possibilities of the newer treatments that in the past few years have been able to do much for some patients or are under active trial to determine their possibilities.

These hospitals have nurses, training schools for nurses, occupational therapists and a trained and disciplined body of attendants who are proud to do their work well. They have hospital wards for the sick, x-ray, surgery, dental service, ophthalmologists, neurologists and the services of specialists in all branches of medicine either visiting in a consulting capacity or resident in the hospital.

All this is as it should be, for any citizen of the state through no fault of his own may come to need the care of such an institution either for himself or for someone in whom he has a deep personal interest. It is well known, however, in these war times that the best hospitals are sorely pressed to maintain as much as they can of their standards of care, and they need the support of an interested public opinion.

The National Committee for Mental Hygiene, which was one of the eight medical and lay agencies participating in the survey, has from its inception been a force for improving the institutional care of the mentally ill and in marshaling public opinion to that need. At this time it is especially important that someone shall look out for these thousands who cannot help themselves.

The magnitude of the problem of state hospital care is appreciated by many only when something occurs to bring it forcibly to their attention.

Population, 376,873

In 1938 there was a daily average of 376,873 patients in the public institutions—now there are undoubtedly more—and they were cared for by 65,316 employes. The patients alone would make up a city about as large as Indianapolis, and the employes exceed the population of Evanston, Ill. Combined they add up to make a city almost as large as Cincinnati.

Twenty-nine institutions are reported as carrying on psychiatric research. Several of them are connected with universities, which is a promising departure from an older period of asylum isolation and aloofness. Sporadic and unostentatious research is likewise in progress in other places. Much is to be hoped from developing new contacts and interesting young scientists in devoting their attention and talents to this promising field where there is much to be learned. Seventy-three of the research projects are in therapy, aimed at keeping the state hospital doors swinging out as well as in.

It is expensive to maintain the

How the Public Can Help the Mentally Ill

See that the state administrative body is devoted to administrative efficiency and free from selfish interests in its administration. Five types of control are listed and any one of them may be good or bad. It is the performance that counts. There is a preference for a medical head of the administration.

Put each hospital under the supervision of a well-qualified physician with adequate experience in mental diseases and in hospital administration and do everything to help him build up a capable medical staff, laboratories, equipment and nursing personnel. Make it possible for all appointees to be the best persons available for the positions, and see that they are secure in their positions as long as they are able and willing to fill them satisfactorily and that their appointment and tenure are influenced by no considerations other than qualifications and performance of the hospital duties.

See that supplies are purchased to the advantage of the hospital, in adequate amounts, suited to the purposes of the institution, and of good quality, and that the patients are never forced to put up with what is sold them for too high a price or because it is not acceptable in the market. Enlist public support for additional resources.

Inquire about commitment procedures and their possible improvement. Get in touch with the management of the institution in your locality to see what are its particular needs and what you can do to help. See if in the present emergency there is anything that can be done to alleviate the great shortage in man and woman-power, and be not too impatient with those who are really carrying on the best they can under great difficulties.

great mass of the mentally ill; and not only for their own good but for the good of the community, as many as possible should be returned as rapidly as possible to a civil and productive status. Almost 59,000 were discharged in 1938 and there were 30,000 deaths in the institutions. Yet there were 11,365 more patients at the end of the year than at its beginning.

In many parts of the United States not only is the care below a reasonable standard but there is less than enough of it. Where hospitals are both accessible and good, as in Vermont, Massachusetts and New York, hospitalization in mental hospitals exceeds 700 per 100,000 population, aged 15 years or over, while in parts of the southern, southwestern and mountain regions, less than half that number is given institutional care.

There is reason to think that the greater part, or perhaps all, of this difference between one region and another lies in the quality of the institutions available and the degree of confidence that they command. It is hoped that this report may contribute something to the awakening of the public which does not know that its mentally ill are not well served or that better standards are enjoyed by others.

When given an opportunity to seek treatment in a well-conducted institution, a considerable number of patients will avail themselves of it. Provision for voluntary admission should be made everywhere with some form of commitment for those who do not realize that they need care.

Commitment should stress the medical aspects of the situation and should be as much as possible like obtaining admission to any other hospital. Laws are archaic that require the sheriff or police to arrest the prospective patient, lodge him in jail, try him in open court before judge or jury or both and then drag him protesting to confinement, as he fears, in strait jacket or padded cell.

Such laws should be abolished from the statute books, although many localities retain these provisions in whole or in part. They interfere with more rights by far than they protect and hamper the treatment and rehabilitation of the patient. Such legal ideas and procedures relative to the care and treatment of the mentally ill have a tremendous effect on the opinion of the patients about the hospital and its physicians and on the community attitude.

They are tolerated only in those regions where psychiatrists and leaders in legal thought alike are habituated to their present arrangements and unaware that better ways have been developed and are in use elsewhere.

In Maryland the certificate of two physicians is sufficient authority for the detention of a mentally ill patient. In Delaware the application is made directly to the hospital, not to a court. In New York cases that are not able to make their own voluntary application, but that do not object to treatment, may be admitted on the certificate of one physician. In some states the care of the patient pending commitment is lodged in the health officer rather than in the police or the poor officers.

Early admission in an atmosphere of helpfulness toward the prospective patient with avoidance of needless hardships, fears and antagonisms goes far to smooth the whole treatment and to enhance the prospects of recovery. There is no disposition anywhere to confine anyone who is functioning well at large or to detain him when he is able to take his place again in the community.

Local interest and leadership are needed to awaken the civic conscience, to institute reforms where they are needed and to maintain and improve standards where they are already good. Some things that still need to be done, on the basis of the U.S.P.H.S. report, are included in the accompanying box.

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Hospitals, *What Next?*

Second and third parts of a series prepared for the benefit of the trustees of Mount Sinai Hospital, New York, by Roman Slobodin, administrative assistant for public relations of that institution

REASONING from the principle that he who pays the piper calls the tune, it might be expected that those who predict the replacement of philanthropy by taxation as a source of support for hospitals would also expect their control and administration to pass into the hands of government. Comparatively few, however, say this in so many words. Rather, there is a general concurrence among them that the state will assume an increasing degree of supervision, especially in the coordination of the work of the hospital with that of other institutions and agencies.

Hospitals Must Work Cooperatively

The typical pattern they envision is outlined by Waldemar Kaempffert: "We must weave into one fabric public research laboratories, prepayment group clinics, and hospitals and put all under competent supervision to maintain the highest standards. Possibly there should be a Secretary of Health at the head of a well-organized department. But that secretary must not be dominated by the American Medical Association. A supreme health authority, composed of leaders of medicine and selected, subject to Presidential approval, by the great medical schools, hospitals and research institutions, would be better.

"Many small centers must become branches or affiliates of those in the large cities, so that new knowledge will automatically saturate the whole fabric, with everywhere uniform quality of medical practice, teaching and medical research. . . . The voluntary hospitals alone cannot solve the problem of national health. They should be preserved, but they should also be interwoven into the new pattern of medical care demanded by new social necessities."

Mr. Kaempffert's statement is by no means irreconcilable with the views of the voluntary hospitals themselves, if Arthur A. Ballantine's opinion may be taken as representative. Mr. Ballantine holds that the voluntary hospital "must demonstrate ability to cooperate in a rounded, over-all program."

"There is a tendency on the part of each voluntary hospital to be a bit too much of a world in itself," he says. "Over-individualization is as much of a danger as over-institutionalism. In the modern world isolationalism is as truly out for hospitals as it is for states."

He goes on to cite a number of spheres in which he believes New York City hospitals can and should cooperate increasingly. These include uniform accounting systems, a rational scale of charges to patients, extension of the Associated Hospital Service (voluntary insurance) to cover ward care and medical as well as hospitalization charges and, finally, "the rounded physical welfare program for the greatest benefit of the entire community."

Will Sacrifice Their Autonomy

The big difference between Mr. Ballantine and Mr. Kaempffert, of course, is that the former wants the hospitals to coordinate their efforts voluntarily, while the latter relies on governmental authority to attain this end. But the point of variance, important as it is, is probably less significant than the fact that they agree that in the future voluntary hospitals will give up a significant part of their individual autonomy, the powers thus relinquished being vested in some outside body, public or quasi-public.

One cannot help wishing that the late Dr. S. S. Goldwater could have been present on the platform with Messrs. Ballantine and Kaempffert to join in the discussion. He had emphatic views on the subject of "remote control" of hospitals.

Speaking with all the authority of his personal experience, Doctor Goldwater declared: "Hospital administration becomes increasingly difficult in proportion to the remoteness of the controlling power. . . . I learned by experience how little a conscientious commissioner can really know about the proficiency and attitudes of the individuals comprising the medical staffs of a string of government hospitals under central direction; although the 27 hospitals under my management were all located in a single city, I know now that I was blind to many of their faults."

Better Record Than Public Hospitals'

Moreover, Doctor Goldwater held that the voluntary hospitals on the whole have a better record for quality and quantity of service and for meeting community needs than have governmental hospitals. In such fields as hospitalization for the tuberculous and the mentally ill, which have been largely served by governmental institutions, he pointed out, the facilities are seriously inadequate and the hospital budgets are starved. Moreover, general hospital care for the sick poor, although it is an accepted government responsibility, is still provided to a greater extent by charitable and religious institutions than by public hospitals.

"There are communities in which the indigent are being neglected declares the advocate of a governmental hospital system; government must, therefore, undertake the administration of all hospitals. As I see it," says Doctor Goldwater, "voluntary

community hospitals are to be robbed of their indispensable freedom and the public deprived of invaluable services not because the voluntary hospitals have failed but because the government has failed."

Summary: Voluntary hospitals are expected to forego part of their traditional autonomy as a contribution toward a well-integrated community health program. There is an issue over the question of whether these powers should be delegated to government or to an authority chosen by the hospitals. In opposition to a universal federal hospital system, it is argued that the government has not made a good record in hospital operation and that existing shortcomings are the fault of government and not of voluntary hospitals.

Services Offered by Hospitals

The most vexed problem in the whole controversial realm of thinking about hospitals is that of demarcating a boundary at which the institution's service should end and beyond which it may not venture on pain of being accused of infringing on the private practice of physicians, impairing their livelihood and stifling free enterprise in the medical profession.

From the discussions there emerges one major thesis that does command a great deal of support, though it is far from being unanimously endorsed. This is the vision of the hospital of the future as the hub of the community's health program.

Says Mr. Ballantine: "For the community health program of the future, the hospital is the very foundation. With the remarkable advances in science and in social living the function of the hospital has vastly expanded. . . . We look forward to the development and expansion of our hospitals for still more intensive and rounded service."

The same idea is advanced in the final report of the Committee on the Costs of Medical Care, in various committee reports of the American Hospital Association, by numerous physicians in the American Foundation survey and by Doctor Henry Sigerist, Dr. Haven Emerson and Dr. Kingsley Roberts, to mention only a few outstanding individuals.

"The time has come," says Michael M. Davis, chairman of the Committee on Medical Economics, "for the hospital to assume the place toward which the combined efforts of many public-spirited physicians and laymen have been developing it for more than a generation. The hospital should be the physical and organizational center through which physicians and the allied professions will supply *all forms of medical service to the community.*" (Italics ours.)

Among the fields into which the hospital will extend its services, the one most frequently cited is that of preventive medicine. On this theme Doctor Sigerist writes as follows:

"The prevention of disease must become the goal of every physician. . . . The barriers between preventive and curative medicine must be broken down. The general practitioner will remain the core of the medical profession, but alone, left to himself, he is lost and cannot possibly practice scientific medicine. He needs the backing of a health center or hospital and a group of scientists whose help he can seek.

"Medical practice tomorrow will of necessity be group practice organized around a health center, which will have health stations as outposts. . . . The people need more than a family physician; they need a family health center where physicians will not wait until a sick man calls on them but from where they will go out into the homes and working places in order to help the people before illness strikes. . . . Whether such a health center should be financed through taxation or compulsory or voluntary insurance is a secondary consideration which will depend on the circumstances."

The Matter of Home Care

As Doctor Sigerist has indicated in the passage just quoted, another field that people of his way of thinking expect the hospitals to enter is that of home medical care. On this subject Michael Davis asserts that the work of the general hospitals and their out-patient departments is not now sufficiently correlated with the general medical care of the patient or with preventive work for him. He says: "There are probably a thousand hospitals with out-patient departments which, by some broadening of scope and staff, could add home care to their present activities and provide complete medical service, but this cannot be done unless some local physicians, qualified to supply general care but at present excluded from the service organization, are admitted to its privileges; nor *unless the economic relations of physicians are altered so as to avoid intense financial competition.*"

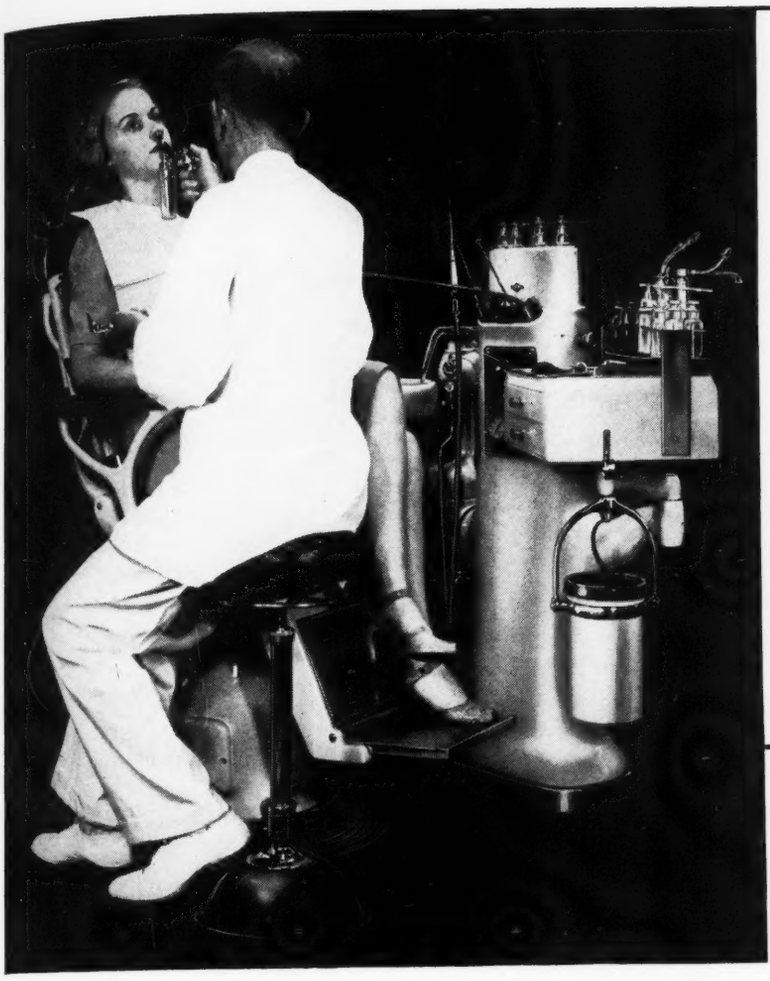
Threat to Free Enterprise?

The passage which we have italicized in the foregoing statement obviously presents the nub of the controversy over the extension of hospital services. A large proportion of the medical profession regards any such proposal as a fatal threat to "free enterprise" in medicine. The American Medical Association is the outstanding champion of the view that free competition among medical men is essential. The extent to which the leadership of the A.M.A. voices the views of physicians as a whole on this subject has, of course, been questioned. But the survey of the American Foundation leaves no doubt that a very large body of medical opinion concurs with the A.M.A., although there is also a large group that is willing to forego the privilege of free competition.

The foundation's survey elicited from many physicians statements to the effect that not only is there no need for hospitals to explore new fields of service but that they have already gone too far. These men feel that the hospitals are now competing unfairly in a number of ways with the doctors, in some cases with the selfsame doctors on whose gratuitous services they depend.

Dr. Morris Fishbein summed up the case against pushing of hospital enterprise into new realms with his famous statement that the capable general practitioner and his little black bag can care efficiently for 85 per cent of his patients without consultations or specialists and presumably without the intrusion of the hospital. This statement has not gone unchallenged. It leads directly to the topic of the future relationship between hospitals and the medical profession.

Summary: A substantial body of lay and medical opinion foresees the emergence of the hospital as the mainspring of an integrated health program for the community. To function in this capacity, some writers anticipate, the hospital will have to serve in fields that it has not previously entered, such as preventive medicine and home care of the sick. Many physicians oppose such a development, as a hindrance to free enterprise and a threat to their livelihoods and independence.



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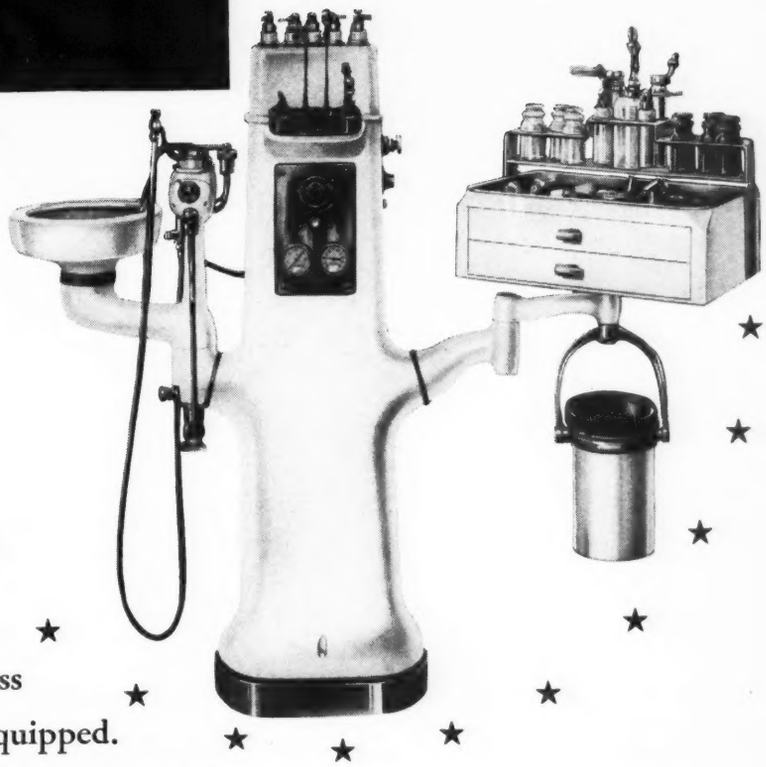

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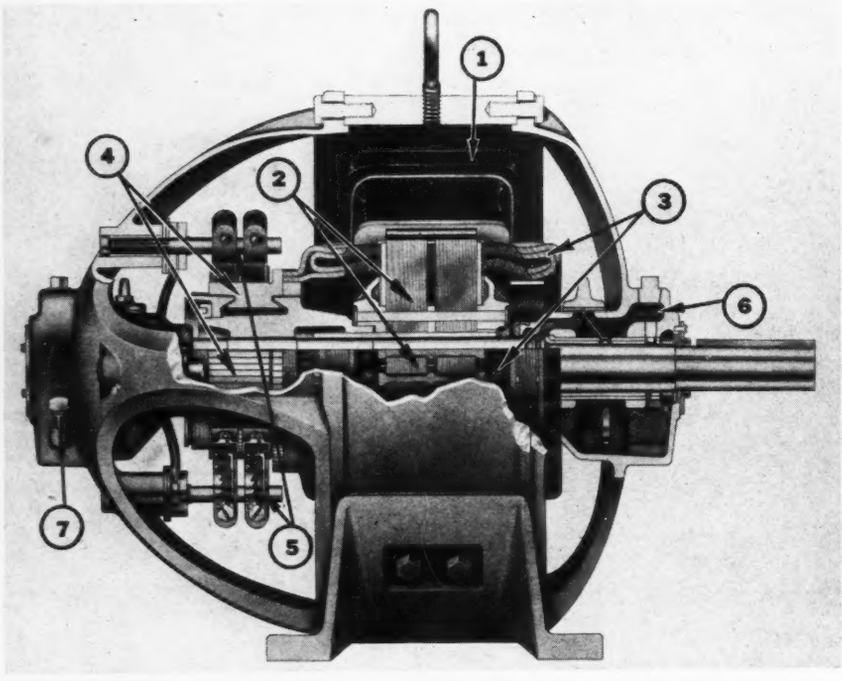
Keep Those Motors Running

Part I



Cutaway view of a direct current motor showing: (1) field coils; (2) armature; (3) armature coils; (4) commutator; (5) the brush rigging; (6) the sleeve bearing, and (7) the oil overflow and filler plug.

HOSPITALS cannot afford breakdowns. An elevator or pump out of service may mean inconvenience or discomfort to a patient. Those motors must be kept running.

The ideal motor maintenance program aims at prevention of breakdowns rather than their repair. Maintenance involves competent, periodic and systematic inspection. A thorough survey of each motor installation should be made and a systematic inspection and maintenance schedule established and enforced. Records must be kept consistently on the schedule selected. Several excellent record systems have been developed and printed, so that it is not necessary to go to the trouble and expense of devising an individual system.

Prevention of breakdowns may be helped by a thorough analysis of the equipment involved. For example, if the difficulty is the frequent tripping of overload relays, the installation of a different type of relay with thermoguards on the motor may enable the motor to carry the loads without an injurious temperature rise.

It is impossible to give any hard and fast rules for frequency of inspection. The following suggestions are based on average conditions found in the hospitals.

Once a week check the oil level in the bearings and see that the oil rings are moving freely. Check the temperature of the motor bearings and primary iron with the hand. Sniff the warm air coming from open motors. The fumes emanating from overheated insulation are unmistakable.

Once a month check the brush holders, brushes and shunts. Blow out the motor with compressed air.

Once a year check the air gap with a feeler gauge. Check the insulation resistance with an insulating testing set. Check the line voltage with voltmeter and the load with an ammeter. Clean out and replace the grease in ball and roller bearings. Check renewal parts stock in light of the past years' experience.

Every two years dismantle the motor. See that all windings are tight. Replace loose wedges and loose bands before dipping them in varnish and baking them. Inspect commutators and commutator connections. Sleeve bearings require no flushing. At intervals of about two years in average service or during general overhaul periods, remove the bracket and wash out the bearing housing; for this use hot kerosene oil and compressed air if available.

All motors depend upon a mechanical assembly of some sort for the transformation of electrical energy into mechanical energy or work. The bearings are an important link in this.

Bearings probably cause more shutdowns, delay and expense than come from any other cause. This is not surprising when it is remembered that they are victims of poor foundations, misalignment, vibration, thrust from couplings, dirt under and over the lubrication and frequently the wrong lubricant; all this, in addition to their real job of supporting a rapidly revolving part.

The first requirement of successful bearing operation is lubrication. This entails more than just an adequate supply of lubricant; the lubricant, the bearing design and its condition must be correct.

Sleeve bearings sustain the essential oil film to prevent metal-to-metal

This discussion has been made possible by the cooperation of J. O. Clevenger and W. W. McCullough of the Westinghouse Electric and Manufacturing Company.

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contact between the shaft and the bearing surface. Properly designed bearings have adequate area for the load, proper oil grooving, working oil rings and suitable materials.

A safe operating temperature for bearings under normal operating conditions is considered to be a 40°C. rise above the surrounding room air. At this temperature a bearing feels only comfortably warm to the hand. Assuming a proper mechanical condition of the bearing, whether sleeve or ball, and the bearing assembly and assuming that proper lubricants are used, temperatures elevated above a 40°C. rise call for immediate investigation.

In a sleeve bearing the oil sticks to the shaft and is dragged along by the rotation of the shaft so as to form a wedge-shaped film between the shaft and the bearing. This film of oil carries the load and prevents metal-to-metal contact. So long as this film is established and maintained there is no metal-to-metal contact in the bearing while the shaft is rotating and, therefore, no perceptible bearing wear.

Two outstanding considerations govern the maintenance of sleeve bearings. The first is to ensure the existence of the oil film once rotation has begun. *Use the right oil.* The second is to minimize the destructive effects of metal-to-metal contact when the film is lost either by accident or during the starting period. *Use the right babbitt.*

For sleeve bearings, proper maintenance keeps oil well filled to the proper level and the oil rings turning freely. New oil should be added only when the motor is at rest to prevent overfilling of the reservoir. Oiling of bearings is more often overdone than underdone. Sleeve bearings that require frequent refilling and thereby leak oil onto the stator windings should be replaced with a sealed sleeve type of brackets and bearings.

It is well known that oil rings generally carry far more oil than is necessary for proper lubrication of the bearing. When running, most of this oil is carried on the outside diameter of the rings. This excess oil causes splashing and spray inside of the bearing housing. Air currents that pass through the housing pick this spray up and deposit it on the motor windings. Sealing the bearing against the entry of air currents is, therefore, necessary and is accomplished in all modern designs by close tolerances, felt seals and air by-passes to offset blower action of rotating parts.

The purpose of the felt washer in these seals is often misunderstood. The real purpose of the felt is to keep out air and dirt. In itself it has little value for preventing leakage of oil once it becomes oil soaked. Bearing wear, which means radial movement of the shaft, spoils the effectiveness of the bearing seals.

All felt seals should be replaced at the same time that sleeve bearings are replaced. These felt seals should be ordered from the manufacturer of the motor. If it is necessary to make them in an emergency, use a high-grade felt not less than ¼ inch thick before compression. Make the inside diameter of the washer the same as the shaft or slightly less. Cut the felt true with the edges at right angles to the surface of the felt.

Oil leakage is generally aggravated by high temperatures. Keep the bearings cool and use an oil that does not foam easily.

Watch for Clicking Sound

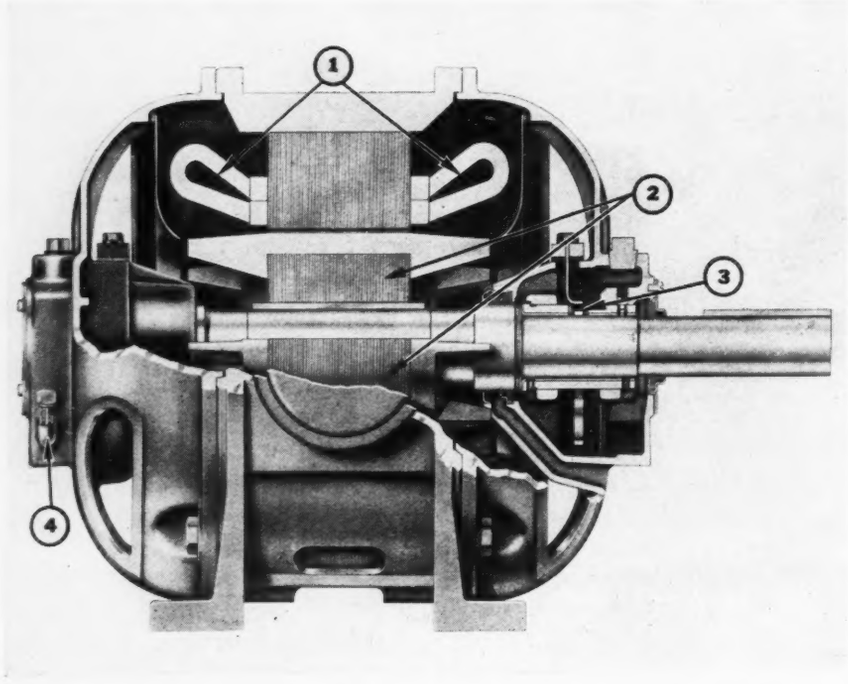
Ball bearings have become increasingly important with the use of totally enclosed and fan-cooled motors. In a ball bearing, a series of steel balls acts as the separating medium, both when the motor is stationary and when it is running.

To keep the steel balls uniformly distributed around the bearing a cage or retainer is used, each ball having its own pocket. The balls have rolling contact with the raceway but sliding contact with the surfaces of the retainer. This means that lubrication is necessary.

Most ball bearings used in horizontal motors are grease lubricated although some supplied with vertical motors use oil. Follow the advice of the motor manufacturer in selecting a suitable grease. Carelessness in allowing containers to remain open often causes trouble from abrasive dirt. Soda-base soap greases are usually preferred on account of their high melting point and their stability. They mix readily with water, however, and tend to form an emulsion.

Ball bearings in distress can usually be detected by undue heating or by unusual noise. Broken or nicked balls cause rapid destruction of the bearing. They can be detected by the "clicks."

If the conventional 40°C. rise above the surrounding air is exceeded, look for an overfilled bearing, since the first result of overgreasing is heating caused by the churning of the grease. The general rule is that the housing should not be over half full. Clean the old grease from the bearing and from



Cutaway view of an alternating current squirrel cage motor: (1) stator coils; (2) rotor; (3) sleeve bearings; (4) oil overflow and filler plug.

"DUPLEX" Assembly: Two Trays and Portable Cradle (see right).

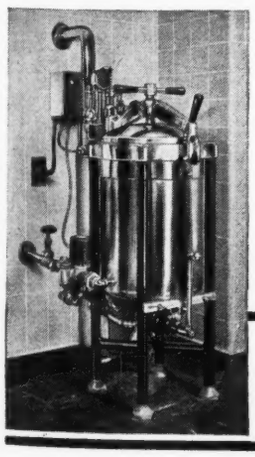
Pressure Sterilization

OF SURGICAL INSTRUMENTS

The new Castle "Duplex" light-weight tray frame and two full size instrument trays, permits your present Dressing Sterilizer to do double duty as a Pressure Instrument Sterilizer. Weighing so little, this easily handled cradle can be put in place or removed in an instant—and can just as easily be laid aside when not in use.

Designed for use in ANY standard 14", 16" or 20" diameter Dressing Sterilizer.

The Autoclave provides ideal sterilization but instruments cannot be washed in an Autoclave without resterilization. For the only complete and comprehensive system of WASHING and STERILIZING in one simple, quick operation, investigate the new Castle Technique. Consult us for the whole story on the latest developments in the technical handling of instruments.



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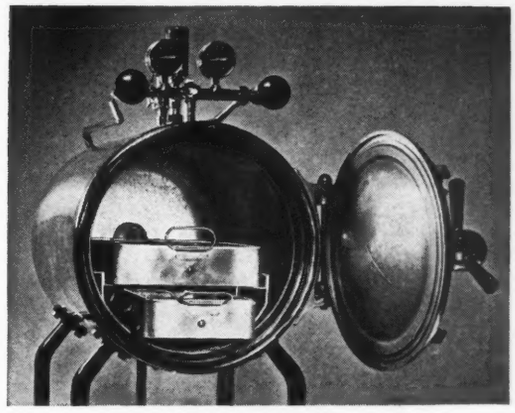
THE CASTLE NO. 100 INSTRUMENT WASHER-STERILIZER *is the only apparatus in which instruments can be washed clean and sterilized—ready for use—in one single operation. Saves instruments, cuts inventory and is better than scrubbing.*



Used as INSTRUMENT Sterilizer

Used as DRESSING Sterilizer

WILMOT CASTLE CO., 1175 UNIVERSITY AVE., ROCHESTER 7, N. Y.

CASTLE STERILIZERS

the housing once a year and replace it with new grease. Average service is assumed.

After the machine is dismantled, the bearing should be carefully wrapped in a clean cloth or paper to protect it from outside dirt. Remove all the old grease from the housing and clean the housing and the bearing either in Stoddard solvent or in carbon tetrachloride.

Remove the final residue of cleaning medium with a light oil before filling the bearing with new grease. The container with fresh grease must be carefully protected from dirt.

ENGINEERS' QUESTION BOX

Eliminating Lime Scale

Question 47: How can we eliminate lime scale in our instrument sterilizers, dishwasher and coffee urns?—A.P., Ont.

ANSWER: To keep scale from forming in sterilizers, use distilled water. This also keeps the cutting edges on the instruments in better condition. If scale has already formed, it can be removed with the use of muriatic acid, used with an inhibitor to protect the metal.

Lime scale formation in a dishwasher can be prevented by the use of one of the several dishwashing machine soap powders now on the market. These leave no scale deposit in the machine. Water that has been treated for hardness will help prevent scale formation in coffee urns.—RICHARD T. POWERS, *chief engineer, Charles T. Miller Hospital, St. Paul, Minn.*

Avoid Spreading Fly Ash

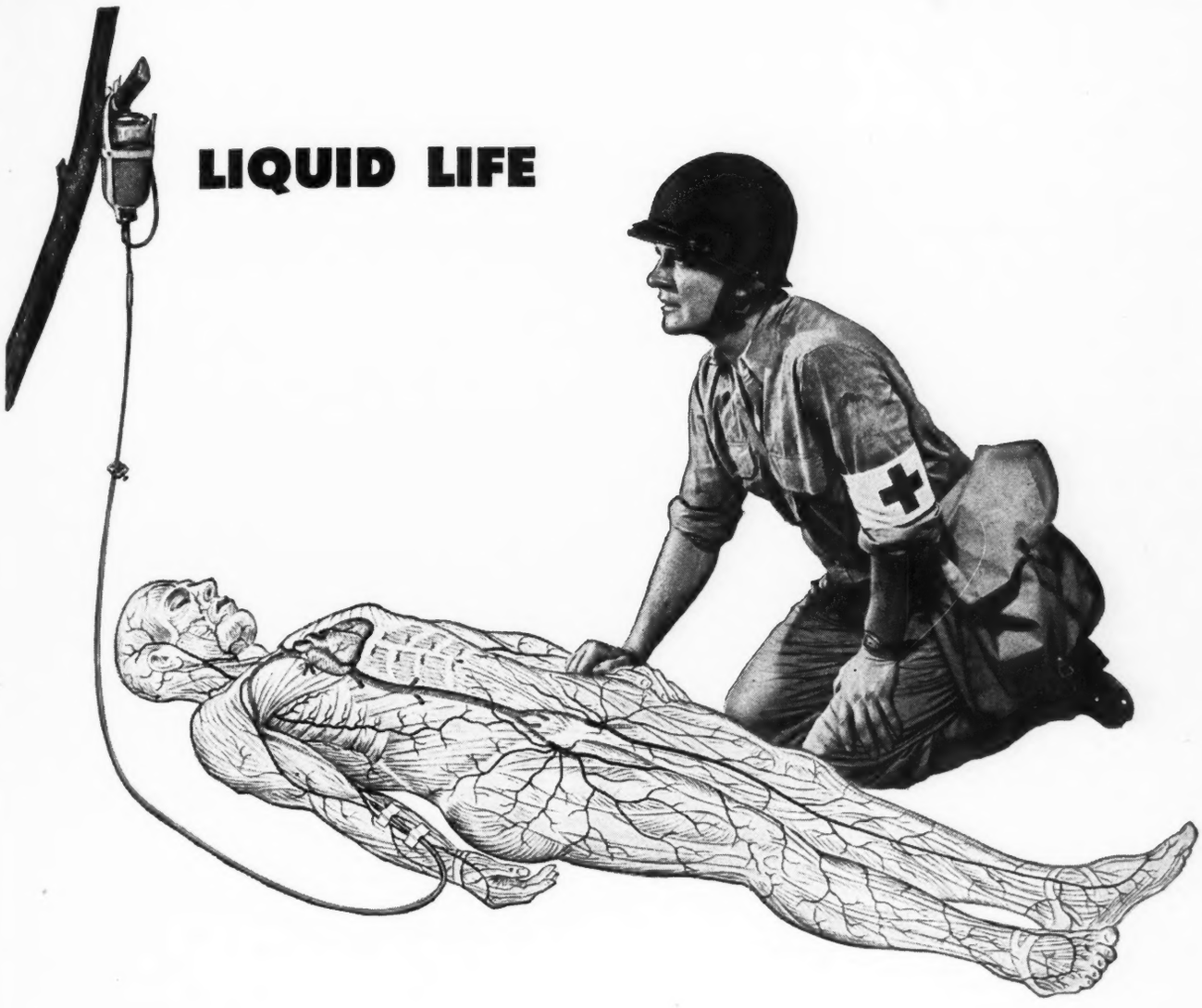
Question 35: If we install a pulverizer, how can we avoid complaints about fly ash? —R.S., Ind.

ANSWER: Pulverized coal equipment is notorious for spreading fly ash through the surrounding atmosphere if it is not efficiently trapped. Boilers designed for use with pulverized coal usually have a fly ash pocket built into the last pass.

If possible, enlarge breeching so that the velocity of waste gases is reduced, provide pockets in the base of the breeching to trap fly ash and arrange to remove these fine ashes by vacuum or by dumping into a water-filled pit.—H. F. VOGEL, E.E., *Sunmount, N. Y.*

Last month's winner of the $5 prize was William J. Jones, Royal Victoria Hospital, Montreal, Que., for Answer No. 1 on "Proper Care of Oxygen Equipment." Mr. Jones, who was erroneously termed chief engineer, is head of the instrument department.

LIQUID LIFE



IN all areas of this global war, blood plasma is saving the lives of countless wounded soldiers by averting the dangers of surgical shock. Extraordinarily effective, easily transported, suitable for any blood type, plasma is among the most potent of medicine's new weapons-for-life.

In the processing of dried or frozen plasma, refrigeration plays an indispensable part . . . and in scores of blood banks throughout the country, the refrigeration is G-E. Ever since the establishment of the first blood bank, General Electric engineers and equipment have made important contributions to the progress of this outstanding medical development.

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HOUSEKEEPING PROCEDURES

Conducted by Alta M. LaBelle

No Maid Shortage Here

Found! An executive housekeeper who isn't having trouble finding maids; in fact, one who admits to having a full quota and isn't anticipating serious trouble about hanging on to them.

This almost unbelievable situation arises out of the fact that Mrs. Mabel Orrison, executive housekeeper of Presbyterian Hospital, Denver, employs only older women and has them work just five hours a day. They are on duty from 7 a.m. until noon, with the exception of two afternoon maids who work six hours a day.

There are several advantages to this setup, Mrs. Orrison reports. In the first place, the maids (there are eight of them) all have their own homes and the five hour working day gives them time to do their own housework and take care of their families. To them, working at the hospital is a pleasant and not too strenuous way of making extra money, 40 cents an hour to be exact. The maids report at 7 and clean the lavatories and take care of the administrative offices before going on the floor. Two maids are needed for each floor of the 160 bed institution and their work includes dry mopping and dusting in the patients' rooms. Taking care of the patients' flowers is the first job of the day. The heavy work, such as wet mopping and high dusting, is handled by the eight porters.

Mrs. Orrison keeps one or two other neighborhood women on call in case one of her maids is ill or fails to show up. However, if these reserves are not available, she calls in the other maids and divides up the work of the missing person among them—and also the pay. The arrangement has proved quite satisfactory.

In addition to their wages, the maids have their uniforms laundered free. They are given no meals, of course; their hours make that unnecessary and so there are no complaints about the food. The eight porters, who work full time, are given one meal a day and are paid 75 cents an hour.

Asked about the value of employee meetings, Mrs. Orrison explains that, while she does not hold them regularly, she finds that an occasional get-together for discussion of the work is extremely helpful. It's a good way for the employes to get things off their chests, and for Mrs. Orrison to do a little "jacking up" if her workers show signs of letting their work slide. For one thing, she tries not to let them use the war as an excuse for poor work but hammers away at the need for extra care and economy with equipment that is increasingly hard to obtain.

Another point that Mrs. Orrison emphasizes at these meetings—and on every possible occasion—is the attitude of the employes to patients. It is human to talk too much, but it is very bad for public relations. She insists that both maids and porters do their work with as little discussion with patients as possible. They must, of course, answer questions courteously, but lengthy discussions about the war or the patient's (or their own) ailments are strictly taboo.

"All together," Mrs. Orrison concludes, "the personnel problem comes back to how you handle people. Mine haven't let me down yet and when I go away on a vacation the work goes on just as it does when I'm here."

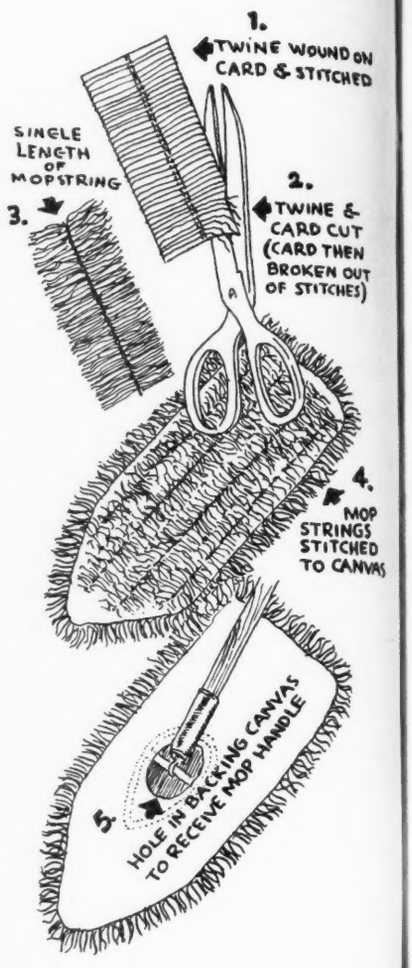
It must be a comforting feeling.

How to Make a Floor Mop

They make their own floor and wall mops out of string stitched on a canvas base at Presbyterian Hospital, Denver. Keeping the supply of floor mops up is the task of one of the afternoon maids whenever she finds that she has time on her hands. The pattern and method of making the mops were devised years ago by some ingenious person, name and position unknown. Here is how it's done:

The heavy twine is wound around a rectangular piece of cardboard and stitched down the center. It is then cut away at the sides and the cardboard is bent in two so that it can be torn away from the string without breaking the stitches. The result is a long row of stitched twine. Four such rows are sewed lengthwise onto a double thickness of canvas and another row is sewed around the outside. The whole thing is then sewed to another double thickness of canvas which has an opening for the mop handle.

The mops are made in three sizes: for walls, corridors and floors in patients' rooms. When the mops are worn down, they are used for waxing the floors.



Incidentally, the head porter at Presbyterian has worked out a satisfactory formula for waxing floors so that they present no hazard to life and limb. Floors are damp mopped about once a week and when this is done a liquid non-slip wax is used in the water. The pail is filled two thirds full with water and the rest is liquid wax. The floors at Presbyterian are clean and shining and there have been no accidents. Dry mopping is all that is needed to keep them in excellent condition the rest of the week.

Rugs or No Rugs

Rugs and carpets are not commonly seen in hospitals, particularly in patients' rooms. But out in Boulder, Colo., where a housekeeper's life is not so complicated by smoke and dirt as it is in many places, rugs are used in all private rooms in the medical wards. A once-a-week vacuuming, a daily workout with the carpet sweeper and an occasional shampooing are all that are needed to keep them clean.

However, clean as they are, the lint from carpets does sometimes affect the respiratory tract and so Boulder Sanitarium and Hospital has hit upon the idea of using linoleum rugs in winter when the upper respiratory diseases are rampant and of bringing out the carpets again in summer.

FOOD SERVICE

The ARMY Conserves Its Food

CAPT. ANTHONY W. ECKERT

Chief of Dietetics, Fitzsimons General Hospital, Denver
Former Administrator, Fitkin Memorial Hospital, Neptune, N. J.

PREPARING CORN FOR FREEZING: Soldiers husk it and the dietitians cut it off the cob and prepare it for freezing and storage.

FOOD conservation and the elimination of waste constitute a definite program at Fitzsimons General Hospital, Denver, under the supervision of Brig. Gen. Omar H. Quade, the commanding officer.

A hundred acre farm produces a tremendous amount of produce for the patients' mess and also a considerable amount of alfalfa hay. Proceeds from the sale of the alfalfa go to the hospital fund for the benefit of patients.

Coupled with this project is a comprehensive educational program for the control of waste, for it is the belief of General Quade that Fitzsimons General, one of the largest Army hospitals in the world (3500 beds), should be a leader that civilian hospitals might well follow.

Realizing the shortage of food and the government's policy to conserve food, General Quade originated the idea of processing the surplus commodities of the farm so that the patients might be served fresh vegetables during the fall and winter months. Fifty acres of the farm are

used for raising such products as corn, beans, carrots, turnips, peas, lettuce and tomatoes. Surpluses of foods are prepared scientifically; after cleaning they are placed in cellulose bags, sealed, put in waxed cardboard containers and frozen and stored in the hospital's cold storage lockers.

Approximately 11,100 dozen ears of sweet corn and 273 bushels of beans have been harvested, members of the dietetic staff, including officers, dietitians, cooks, bakers and enlisted personnel, volunteering their services. Other products harvested during the summer months were almost ample to provide fresh vegetables for the messes.

The important goals of the Fitzsimons General Hospital food conservation program are as follows: (1) eliminate food waste; (2) supervise the distribution, preparation and consumption of foods; (3) weigh garbage and make analysis of percentage of edible waste; (4) study all menus for nutritional adequacy and careful planning; (5) reduce the amount of leftovers and use the remainder immediately; (6) improve the preparation of food; (7) study the likes and dislikes of the consumers as to food served; (8) study market conditions of seasonal and out-of-season commodities; (9) review types and arrangement of equipment; (10) supervise closely the kitchen and personnel; (11) study the problem of ordering and storing food, especially perishables; (12) utilize all commodities efficiently, and (13) check the results of these efforts.

One of the most important factors in this conservation program is the daily inspection of menus in order to ascertain that the proper amount of food is prepared for patients and enlisted personnel with the minimum amount of waste. Each person is made conscious of the fact that he may take all the food he wants but under no circumstances should he take more than he should eat.

As a part of the daily routine, General Quade frequently eats at the mess with his men and makes careful inspections as to the preparation of the food and its quality. As part of the educational program various posters are distributed about the mess calling attention to the quantity of food that should be consumed. Butter is prepared in whole and half squares. Bread is likewise cut in whole or half slices.

A careful study is made of the garbage disposal. Each day a careful analysis is made to determine what percentage of garbage is edible waste. The garbage is weighed daily.

The important job of feeding sick in an Army hospital must be in the hands of those who are thoroughly trained and capable of careful supervision and efficient administration. They are required to meet any dietetic problem that may arise in such a tremendous institution.

The dietetic department at Fitzsimons General Hospital is highly specialized. Its personnel consists of more than 250 civilian employes who are well trained under the department head, known as the chief of the Dietetic Branch. This officer has under his direct supervision the chief dietitian and 13 staff dietitians. All these dietitians are now commissioned officers of the U. S. Army.

Directly under the chief dietitian, the hospital conducts a school for student dietitians, which is approved by the American Dietetic Association. The class consists of six students but 20 additional students are planning to report in November. After the completion of one year's study in theory and practice, these students will be offered a commission in the U. S. Army as second lieutenants.

The following are a few of the methods we use in helping to conserve food:

1. Left-over cookies are ground and used for a topping on open-face cobblers.
2. Orange marmalade, which is not a popular item with the men as a spread, is used on top of plain white cake. They always eat it then!
3. Left-over fruit cup is used in gelatin for dessert.
4. Dry bread and bread heels are used for stewed tomatoes, bread pudding and dressing.
5. Bones from the butcher shop are used for soup stock.
6. Small rib bones from front quarters of beef are used for barbecued ribs.
7. Left-over beef roast is served the next meal as hot beef sandwiches.
8. Sliced tomato ends are used in soup.
9. Celery leaves are used in soup for flavoring.
10. Butter left on plates is collected and used in cooking.
11. Left-over peas are combined with carrots and served as a combination vegetable dish.

Dehydrated Carrots, Sweet Potatoes

Now Available to Hospitals

WASHINGTON, D. C.—Inasmuch as production of dehydrated carrots and sweet potatoes has exceeded government requirements, these products are available for use through amendment of Distribution Order 30 to civilians.

The total amount available, while not great enough for general distribution through retail outlets, should be of value to hospitals in augmenting their rations of other processed vegetables, according to an official in the War Food Administration in an interview October 6.

In order to get further information concerning these dehydrated vegetables, each hospital should get in touch with its own jobber, the official explained. The emphasis at this season is on carrots.

Dehydration of carrots and sweet potatoes saves labor in kitchen preparation and simplifies storage and transportation, factors of great importance in overcoming labor shortage problems, the official pointed out. Both foods are suitable for use in many recipes that call for cooked carrots or sweet potatoes as ingredients. Food authorities suggest sweet potato or carrot pies, thus adding to the more limited variety of pie fillings obtainable under war-time conditions.

It is believed, said the W.F.A. official, that the experience gained in the cooking of dehydrated carrots and sweet potatoes will facilitate utilization of other dehydrated vegetables or fruits that may be made available to civilians later.

A Dietitian Talks of "AIDES"

Methodist Hospital, Brooklyn, N. Y., was one of the first in the country to graduate a class of dietitian's aides. In this article Marion Randall, chief dietitian, reviews the results to date and offers suggestions for others that are organizing such classes

"IT IS difficult to imagine how we could have carried on during the past few months without our dietitian's aides."

Marion Randall, chief dietitian, Methodist Hospital, Brooklyn, N. Y., having graduated two classes, the first numbering 14 and the second 10, reviews the results thus far with complete satisfaction.

As this is being written Miss Randall is making plans for a third class, this one to be held for the benefit of women who are employed during the day but who are willing to donate some of their time over the week end.

Miss Randall frankly confesses that she had some misgivings when she started this training program last spring. The outline for the course for dietitian's aides had only recently been completed by the American Dietetic Association and the American Red Cross and acknowledgedly there were kinks in it that would have to be ironed out when it was put into actual practice. Furthermore, there was the problem of how she was going to find time to provide the necessary training.

On the other hand, the need was becoming daily more pressing and the excellent service she had been receiving from Red Cross canteen workers convinced her that volunteers had much to offer in the dietary department provided they were properly encouraged and made to feel that there was need of their services.

It Was a Trial Balloon

It was decided that the Methodist Hospital course would be in the nature of a trial balloon, its progress to be noted carefully by dietetic and Red Cross officials and to serve as a guide for further training in this and other institutions. Dorothy Jones, nutritional director of the Brooklyn chapter of the Red Cross, enrolled members for the class and enthusiastically assisted in getting the mechanics of the project set up.

While admitting the many problems involved, Miss Randall is enthusiastic. She realizes the feeling that many dietitians have about the undependability of volunteers and she recognizes, too, what it means in days such as these to take time from essential duties to train or to supervise the training and work of these outsiders. She has heard it said that these women will not do the menial tasks for which workers are most needed.

Skeptical at the Start

For the benefit of the skeptics, Miss Randall admits that she originally shared their feelings in measure but has, however, found that the faithfulness of the volunteer to her post depends largely upon the manner in which she is handled, on whether or not she is made to feel that her services are needed.

With regard to the sacrifices that the dietitian may have to make to conduct such training, Miss Randall believes any dietitian will find the effort worth while. It has been her experience that these workers will do anything that is asked of them and she has not yet had one refuse to do a task no matter how menial. In fact, many times they will perform the humblest functions more willingly than the paid worker, particularly the paid worker of today.

The first class of Methodist Hospital dietitian's aides, which was graduated last June, was carefully selected for the reasons described. In preparing the outline for her course, Miss Randall followed the pattern established by the American Dietetic Association and the American Red Cross as published in The MODERN HOSPITAL last May. Certain minor changes contributing to a simplification of the original procedure were necessary to ensure its adaptation to the facilities of Methodist Hospital but, in substance, the principles were identical.

The course as given comprised 15 sessions, the first 10 of which were classwork followed by observation. The last five were practical experience, under supervision. From such generalities as the orientation of the hospital in the health picture and the organization of the dietary department, the work progressed to food preparation, setup of trays and the mechanics of food service.

Final examinations, that bugbear of all volunteers, were purposely minimized, the written questions being kept brief and simple. This is important, Miss Randall believes, if you are to get sufficient recruits for your classes. Instead of examinations, the aptitude of the students for the work, the interest they manifested in it and their attitude toward the performance of the various duties were checked closely from week to week.

Of the 16 members in the first class, two who obviously were unsuited dropped out after the first few lessons. The other 14 were graduated and started their 150 hours of service as agreed. Five of the Red Cross canteen workers sat in on several of the classroom sessions.

Rescue Work in August

Volunteer help naturally slacks off during the summer, yet many of these workers who were graduated at the start of the vacation season began work immediately. Fifty per cent of them continued to help out during the entire summer, which in itself is sufficient proof to Miss Randall of their value to the hospital over the long term. During the month of August particularly, she does not know how the hospital could have pulled through without their aid.

Most of this first class are women with homes and servants of their

FIVE NEW CHARTS

to help you teach new employees to save Fuel and Food

Immediate help to solve these kitchen problems is right at hand if your ovens, steam tables, fryers and coffee urns are equipped with Robertshaw thermostats. These thermostats were made and installed to take the guesswork out of cooking—these charts will help teach inexperienced employees to cook well and economically by operating thermostats correctly.

These charts tell how to get more servings from roasts by reducing meat shrinkage; how to insure uniform, good quality baked goods; how to improve quality of fried goods while saving frying oil; how to produce better brews while saving coffee and fuel; how to operate steam tables for best results with minimum consumption of fuel. Each is ten inches by fifteen inches, printed in two colors on durable cardboard—easy to read and simple to follow.

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Please send me the set of five instruction charts to help teach inexperienced employees to save food, fuel and vitamins. I enclose twenty-five cents to cover printing and mailing costs.

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*Street*_____ *City & State*_____

own but they are willing to devote from three and a half to four hours a day twice each week to assist in the hospital kitchen, running the dishwashing machine, preparing vegetables, scrubbing the ice boxes, serving trays and helping out wherever the need exists.

Believing that, with the advent of the winter season and the growing seriousness of the labor situation in hospitals, similar courses will be organized all over the country, we asked Miss Randall to pass along any observations she might wish to make on working with such volunteers in order to get the maximum service.

Dietitian Must Set Example

"The success or failure of the plan in my opinion," she states, "depends on the cooperation between the dietitian and the volunteers. You get from the volunteer just as much as you give to her.

"The dietitian must set an example. She must let the volunteers see that she, too, is ready to step in and do anything that may be necessary. If she will work along with them, she will soon find out how willing they are to do anything that is asked.

"The dietitian must plan for their services as definitely as possible, so that the volunteer who reports for duty at 9:30 a.m. will not be required to hang around until 10 a.m. with nothing to do. Unless she is given a definite assignment and made to feel that there is need for her services, she will lose interest.

"It has been our practice to put the volunteer to work wherever we are short of help. This may be in the vegetable preparation room, the pantries or the dishwashing unit. We never ask volunteers to do heavy lifting or to mop floors. Discretion on the part of the dietitian is essential in the distribution of work. Some volunteers may not be strong enough to pitch in during the peak load of the morning or noon hours but can fill in well during the afternoon and assist in the preparation of supper. Their tasks should be assigned with individual requirements in mind.

"It is likely that some skepticism may manifest itself on the part of certain members of the dietary staff toward volunteer workers. 'More trouble than they are worth.' 'Easier to do it myself than show them.' Such comments need not be taken seriously. The chances are that when it becomes evident how efficient many of these workers are, the tune will change to one of: 'If you have any to spare who might help me for a while this morning, I would appreciate it.' As one of my workers remarked to me recently: 'Why don't I get my share of these volunteers?'

"The fact that they do work out so well makes it important to see that they are not imposed upon. The responsibility for fair play to the volunteers rests with the dietitian in her interpretation of their services to the various members of her staff.

"In every group of volunteers one or two will be found who are convinced that greater efficiency would result if the work was handled differently. They come with all sorts of suggestions which the dietitian must meet tactfully, honestly and patiently. At such moments she has need to count ten and remember how much worse off she would be if she did not have the volunteers.

"There will be some, no doubt, who are recipe collectors and who will appear with some of their favorites that they are convinced will add variety to the hospital menu. It does not take long to convince them that the preparation of such dishes is quite practical for the home but too time-consuming for institutional service. It is revealing to others to discover that quantity cooking is far different from that which provides just a few portions.

"It will not be surprising if at one time or another the dietitian gets a plea to use a variety of colored paper napkins. 'So much more interesting than white.' There is but one way to handle such a suggestion, to explain that there is a war on and that colors simply are not available.

"These are not the problems that they seem and most of them can be handled without great difficulty. For the most part these volunteers are quick to sense the situation and soon develop an entirely new perspective of hospital food service. They learn the difficulties in getting food up to the floors as hot as the patient and the dietitian might like, the reasons why meals cannot always be served at the hours to which the patient is accustomed and what steam tables can do to the best foods no matter how skillfully prepared.

How Find Time to Train Aides?

"The biggest problem of all that faces the dietitian in training these aides is unquestionably her lack of time. The suggestion is made, for what it may be worth, that some qualified dietitian, previously employed by the hospital but now retired and living in the community, might be willing to assume the responsibility for the project.

"Naturally, difficult situations will arise. Frankly, there may be an aide who is not adapted to the work and who may cause trouble. It would be better to discourage that person at the start, suggesting that she find some other type of volunteer service that would be more to her liking. Such cases, however, are exceptional.

"May I repeat again that much depends upon the attitude of the dietitian. The more she gives of herself to them, the more she will benefit. Personally, I can state in all truthfulness that I have received far more time from my volunteers than I have given to them. They are truly indispensable in times like these."

And so the flight of the trial balloon that the dietary department of the Methodist Hospital sponsored last spring in close cooperation with the American Red Cross has proved highly successful. News of its progress has spread rapidly and similar projects are being started. The days of experiments are over. Dietitian's aides like nurses' aides have come to stay—for the duration.

You CAN Get Eggs

A priority rating has been devised to assist hospitals in getting shell eggs enough for patients who have special need for this easily digested protein food. The rating will not be granted, however, until all other methods of meeting egg requirements have been exhausted.

Egg shortages are expected to be only temporary and will be localized. Production is the highest in history but a growing transportation and distribution problem may result in temporary inconveniences.

In localities in which priorities become necessary, the regional Food Distribution Administration office will work with hospital purchasing agents.

★ FOR SPECIAL ATTENTION OF DOCTORS OVERSEAS! ★

Doctor! Will you give my daddy a message?

DADDY doesn't know me very well, on account of he's overseas and he hasn't seen me yet. But he worries about me something awful.

Why, just the other day I heard Mama say that he's all upset because our fats are rationed, and tin for canning is so scarce. He's afraid Mama may not be able to keep me on the food my doctor prescribed when he found she couldn't nurse me.

Tell Daddy not to worry, Doctor. The men in Washington are doing everything in their power to provide the folks who make S-M-A (that's my brand) and all the other manufacturers of scientific infant formulas with enough cans, enough special fats, and enough other ingredients to give us babies our full quota of nutrition.

See, Doctor? Daddy needn't worry for a single minute! Our government isn't going to let its babies go without foods they need so they can grow up to be strong and healthy. Just remind him, Doctor—that this is America!

S. M. A. Corporation, Chicago, Illinois.

SMA

INFANT FEEDING FORMULA

A.D.A. Analyzes War-Time Worries

Personnel and rationing still lead as the dietitian's principal problems

"NO ONE needs to go hungry in this country," Claude R. Wickard, U. S. Department of Agriculture, assured reporters who waylaid him when he arrived in Pittsburgh to address the war conference of the American Dietetic Association, October 19 to 22. He added, however, that "if someone especially likes butter or steaks, he may go hungry for those."

In his address to the 1000 food specialists assembled Secretary Wickard urged them to work toward fulfillment of the world-wide program for better nutrition laid down at the United Nations Conference on Food and Agriculture at Hot Springs, Va. The speaker emphasized the importance of maintaining a high level of nutrition after the war.

"Next to the winning of this war," he stated, "there is nothing more important to us right now than the kind of world we are going to have after this war. Every step we take will help. The time to begin is now."

Turnover Up to 400 Per Cent

The personnel problem, one of the dietitian's greatest headaches, was thoroughly analyzed by Dr. Charles F. Wilinsky, executive director of Beth Israel Hospital, Boston. In discussing the importance of paying a living wage, Doctor Wilinsky made the statement that hospitals had experienced a turnover in personnel of from 75 per cent among the professional groups to 400 per cent in the maintenance, kitchen and other departments that employ low grade labor.

"It is of great advantage to include in the wages of employes the cash value of maintenance which gives freedom of choice to live and eat in or outside the hospital," the speaker advised. "This results in a better type of employe and often shows him that he is actually receiving wages that compare favorably with those paid by industry.

"Vacations and sick leave with pay will yield dividends in good will. Reasonable hours, facilities for health protection and hospitalization are essential. The custom of demanding split hours from employes is unsatisfactory.

"A satisfactory dietary department is a tremendous asset to the hospital," Doctor Wilinsky concluded.

Elizabeth S. Hedgecock, University of Maryland Hospital, Baltimore, presented a summary of the answers to a questionnaire sent out at the request of the Office of Price Administration regarding the effects of rationing upon the hospital problem.

The difficulties encountered, it was revealed, have been many and varied. The problem has been complicated by high prices, scarcities of fresh perishable foods and lack of labor. Processed foods present one of the greatest problems; 65 per cent of the hospitals have not been able to make satisfactory substitutions; 48 per cent of all processed foods are used for special diets.

Meatless days, of course, were reported by many of the hospitals. The average number of times per week that meat is served has been reduced from 11 to seven and choice of meats by both patients and personnel has been restricted or eliminated altogether. Sixteen per cent of all meat, it was disclosed, is reserved for special diets.

In answer to the important question as to whether the diet is adequate from a nutrition standpoint, 90 per cent of the hospitals reported that an adequate level has been maintained.

However, Miss Hedgecock pointed out that "the hospitals answering the questionnaire were almost all private hospitals which operate on larger food budgets than do county and state institutions. Prewar custom in the latter institutions called for meat service only six times a week. Their operation under rationing on a percentage basis causes grave concern as to the nutritional adequacy of the food."

Speaking of shortages, the Army needs dietitians. Painting a picture of the attractions of Army life, Lt. Mary Streidl, Station Hospital, Fort Leonard Wood, Missouri, emphasized that the dietitian in the Army can use her experience and training to the utmost. She works with the mess officer and assists with all problems and is entirely responsible for the patients' food service.

Duties of Head Dietitian

"Medical department dietitians," Lieutenant Streidl explained, "are really members of the medical department of the Army; they are not part of the Army Nurse Corps although they do have the same rights and uniforms. The head dietitian is charged with instructions, assignments, discipline and performance of duty of all dietitians on duty at the hospital. She acts as a liaison between the dietitians and the heads of other departments."

An ideal plan for food production in the state hospital was outlined by Katherine E. Louser, Norristown State Hospital, Norristown, Pa. Miss Louser suggested that the institution have under cultivation sufficient land to supply all of the vegetables and at least part of the fruits for its daily needs and preserve a sufficient quantity to provide the hospital with vegetables and fruits during the winter months.

In institutions that have little land available, the speaker pointed out, it is important that the crop program be well planned in order to obtain from the land under cultivation the greatest amount and variety of the most valuable foods.

New officers elected at the session are: president-elect, Maniza Moore, director of dietetics, Vanderbilt University Hospital, Nashville, Tenn., and treasurer, Mable MacLachlan, University of Michigan Hospital, Ann Arbor.

December Menus for the Small Hospital

Mabel B. Gladin

Former Dietitian, St. Elizabeth's Hospital, Richmond, Va.

Day	Soup or Appetizer	Meat, Fish or Substitute	Potatoes or Substitute	Vegetable	Salad or Relish	Dessert
1.	Vegetable Soup	Spanish Limas With Bacon*			Mixed Vegetable Salad	Apple Crisp
2.	Beef Consommé	Lamb Pie With Potato Topping		Frosted Spinach		Ambrosia
3.	Chilled Tomato Juice	Broiled Halibut Steaks	Mashed Potatoes	String Beans		Lemon Meringue
4.	Scotch Broth	Stuffed Breast of Veal		Creamed Cauliflower	Head Lettuce, French Dressing	Baked Apple
5.	Apple Juice	Roast Turkey, Dressing	Rice With Gravy	Peas and Carrots	Celery, Olives	Raspberry Sherbet
6.	Vegetable Soup	Boneless Rump Roast	Candied Sweets	Asparagus		Tangerines
7.	Tomato Juice	Peanut Butter Cutlets	Baked Potatoes	Fried Parsnips	Lettuce Salad	Apple Sauce, Cookies
8.	Fresh Fruit Cup	Chicken à la King in Timbales	Rice	Broccoli, Hollandaise Sauce	Celery and Carrot Strips	Baked Custard
9.		Broiled Frankfurter Rings With Spaghetti*			Lettuce, Egg Salad, French Dressing	Cup Cakes
10.	Vegetable Soup	Fried Oysters, Catchup	Creamed Potatoes		Sliced Tomato Salad	Fresh Fruit Cup
11.	Chilled Vegetable Juice	Meat Loaf, Tomato Gravy		Creamed Diced Celery and Carrots	Coleslaw	Gingerbread, Lemon Sauce
12.	Fruit Cocktail	Smothered Steak	French Fried Potatoes	Buttered Cauliflower	Mixed Vegetable Salad	Chocolate Ice Cream
13.	Scotch Broth	Broiled Liver	Baked Stuffed Potatoes		Grapefruit, Avocado Salad	Bakery Pound Cake
14.	Tomato Juice	Eggs à la Duchesse	Baked Acorn Squash		Waldorf Salad	Carrot Pudding
15.	Cream of Celery Soup	Broiled Ham	Baked Sweets	Cabbage	Sliced Tomatoes	Apple Cobbler

(*Continued on page 104*)

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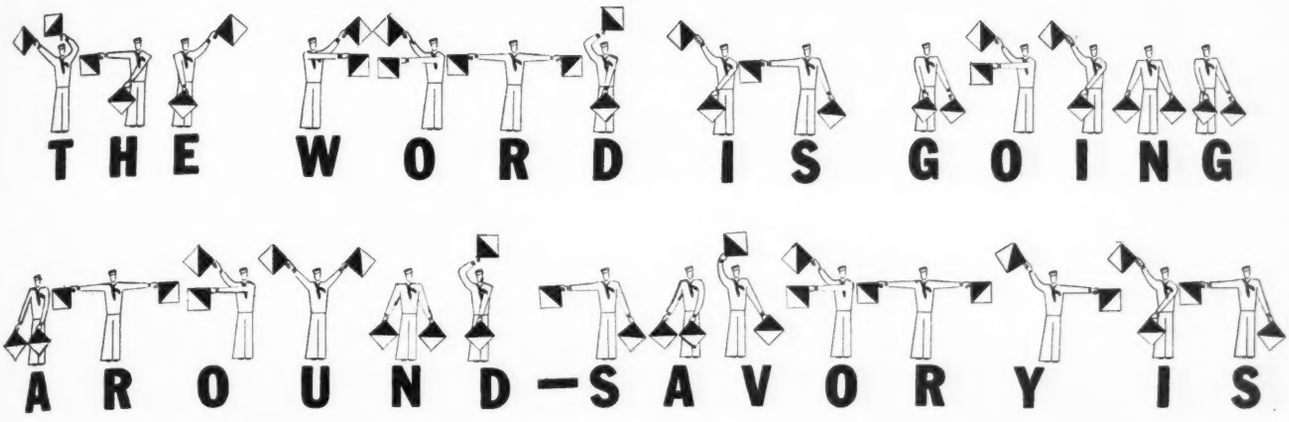
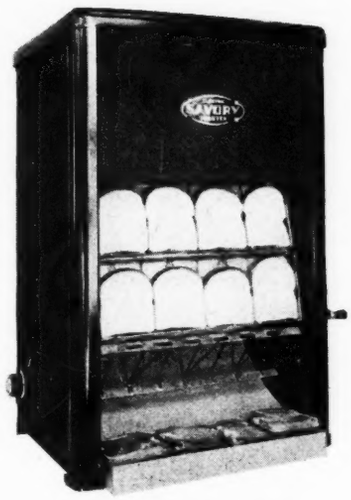
December Menus for the Small Hospital

Day	Soup or Appetizer	Meat, Fish or Substitute	Potatoes or Substitute	Vegetable	Salad or Relish	Dessert
16.	Cream of Tomato Soup	Savory Beef Potpie		Harvard Beets	Mixed Fresh Fruit Salad	Butterscotch Pudding
17.	Tomato Juice	Crab Soufflé	Baked Idaho Potatoes	Buttered Peas	Stuffed Celery	Ambrosia
18.		Spareribs and Dumplings*	Sauerkraut		Waldorf Salad	Cottage Pudding, Chocolate Sauce
19.	Fresh Fruit Cup	Chicken Pie	Sweet Potato Soufflé	Brussels Sprouts	Celery Hearts	Orange Sherbet
20.		Planked Hamburg	Parsley Buttered Potatoes	String Beans	Head Lettuce	Banana Pudding
21.	Cream of Corn Soup	Cottage Cheese and Peanut Loaf, Tomato Sauce		Frosted Spinach	Fruit Salad	Graham Cracker Cream Cake
22.	Cream of Pea Soup	Braised Beef With Vegetables (Onions, Celery, Potatoes, Carrots)			Sliced Tomato Salad	Apple Sauce Cake
23.	Apple Juice	Escalloped Chicken With Noodles		Peas and Carrots	Spring Salad	Prune Whip, Custard
24.	Vegetable Soup	Fried Fish, Tartare Sauce	Mashed Potatoes	Baked Squash	Mixed Vegetable Salad	Lemon Pie
25.	Honey Dew Melon Balls	Roast Turkey, Giblet Gravy	Dressing	Cauliflower au Gratin	Celery Hearts, Olives, Cranberry Sauce	Eggnog, Fruit Cake
26.	Consommé	Baked Ham	Candied Yams	Asparagus, Hollandaise Sauce	Waldorf Salad	Pound Cake
27.		Smothered Steak	French Fried Potatoes	Green Beans	Sliced Tomatoes	Plum Pudding, Lemon Sauce
28.	Clear Tomato Soup	Baked Rice and Cheese		Mashed Turnips	Orange, Onion and Romaine Salad	Chocolate Cream
29.		Rolled Lamb Shoulder, Spiced Apricots	Dressing	String Beans	Carrot, Raisin, Celery Salad	Grapenut Pudding
30.		Spanish Short Ribs*	Baked Squash	Creamed Celery	Molded Vegetable Salad	Grapes
31.	Cream of Celery Soup	Shrimp Creole	Baked Potatoes	Stewed Corn	Coleslaw, Sweet Relish	Jelly Roll

*Dish suitable for personnel menus but not for patients' general diet.

Recipes will be supplied on request by The Modern Hospital, Chicago.





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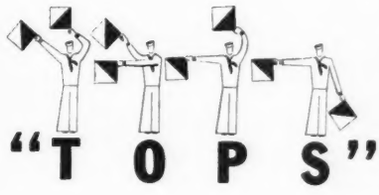

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Perhaps it's your own Fault

Lesson in applied psychology for that "underprivileged" pharmacist

FLORENCE KING
Administrator, Jewish Hospital of St. Louis

THE universal theme song of every hospital department appears to be "Nobody Loves Me." Whenever I prepare an article relating to any department within a hospital, my reference reading reveals the fact that that particular department suffers the delusion that it is the neglected stepchild of the institution. When writing about the storeroom I recently compared it to that pathetic creature "the forgotten man."

Now I find I was wrong. It is the pharmacy and it alone that is "nobody's darling." Indeed, one of the reports of the pharmacists' section at last year's American Hospital Association meeting started with this melancholy statement: "The outstanding point made in the well-attended session was that the hospital pharmacy has been neglected in the average case."

Another report stated: "No superintendent has the proper interest in or due respect for the pharmaceutical department," and still another dwelt on the fact that while other departments have come into their own, "the hospital pharmacy is still in the unenviable position of a storehouse of a heterogeneous and uncontrolled accumulation of drugs."

Basement Psychology

The picture of wanton neglect, of pharmacies buried deep in dark, dank corners of dungeon-like basements, the pharmacists unappreciated and forlorn, was about to plunge me into a sea of despair, when I came upon a refreshing article by Ray Amberg of the University of Minnesota Hospital,[1] in which he heralded the pharmacy as a living, breathing unit of the hospital.

Optimistically, Mr. Amberg said: "It must have the same nourishment and fostering of the hospital administration as any other professional unit of the organization. . . . There is no more important single unit in any hospital." If this is true, let the pharmacist assert himself and earn the status that he claims should be his.

A Persecution Complex?

If from an architectural standpoint it is deemed wise to place the pharmacy on the ground floor, there is no reason on earth why the pharmacist should develop a persecution complex and feel himself one of Gray's gems of "purest ray serene" consigned to the "dark unfathomed ocean cave." The hospital kitchen is usually located on the ground floor, yet that doesn't cause the dietitian to hang her head in shame, nor does it prompt the rest of us to scorn the apple pie that issues from such a kitchen.

Isn't it time that the pharmacist stops whining about the obscure location of his department and the scant recognition he has had? Can't he discard his persecution complex and instead exhibit a deal of self-assurance? The hospital pharmacist, in most states, by the time he is licensed, has a theoretical and practical background that should make it possible for him to take his place without apology beside other professional groups in his hospital. If he doesn't merit that respect, who but he is to blame?

On the premise that it is the pharmacist's duty to seek his own place in the hospital's sun, his initial job is to convert his administrator to the idea that he is a professional man in charge of a department as vital to the hospital and its patients as the laboratory and the x-ray department; that his professional duties should not include those of a handy man or a purveyor of chocolate bars and electric toasters. The administrator has no right to prostitute the pharmacy by stocking its shelves with wares of an unprofessional nature.

We facetiously talk about the commercial drugstore where we get lost in a maze of bath towels, electric irons and luggage before we can discern the prescription counter and then inconsistently expect the average hospital pharmacist to stop filling a prescription to man a gift counter or to serve a sandwich.

It is true that the smaller hospitals, in order to have a registered full-time pharmacist, must give him additional duties but, if this is necessary, can't his supplementary work be concerned with professional supplies or duties? Is it not difficult for the surgical chief to look upon the pharmacist as his professional co-worker when he beholds him retailing baby bonnets from the gift counter or dispensing coffee and doughnuts?

Is Hub of the Wheel

The next step is for the pharmacist, through his administrator, to merit the recognition of his colleagues in every department of the hospital. L. W. Busse has said: "The pharmacy is the center from which all other departments must receive their drugs and supplies; therefore, the hospital pharmacist must of necessity be acquainted with the

From a paper presented at the convention of the American Hospital Association, Buffalo, N. Y., September 1943.

[1] Hosp. Mngt. 54:84 (Nov.) 1942.

needs and wants of the other departments in the hospital. The pharmacy may be pictured as the center or 'hub' of the wheel and the related departments, the spokes that radiate from the hub."[2]

With every department dependent upon, and working with, the pharmacy, the pharmacist has unlimited opportunities to "sell himself," as it were, and to demonstrate that his is one of the most important services a hospital provides. He can be content with managing a drug room, doling out aspirin and talcum powder on request or he can prove himself an expert in his field by serving as a consultant and teacher to every last department. In his contacts with the various departments he can suggest ways for the pharmacy to contribute to their work and to cooperate with them by introducing new procedures learned through his association with fellow pharmacists and sales representatives and from information gleaned from pharmaceutical literature.

On an Equal Footing With Doctor

Granted that it is not only the pharmacist's prerogative but actually his duty to take his place in the hospital's professional circle, can we not designate that place as hand in hand with the physician? Since patients trust their very lives to the pharmacist's knowledge, skill and judgment, is it not fair that his professional standing and responsibility to the patient have an equal footing with that of the physician?

If the pharmacist's responsibility to the patient coincides with that of the physician, should not the two professional men work side by side, consulting and sharing ideas with each other? The educational background of the qualified pharmacist with his thorough preparation in the basic sciences enables him to speak the doctor's language and should give him sufficient confidence to hobnob with him as a professional equal.

Formerly, the pharmacist was often looked upon by the physician as merely an automaton who blindly filled his prescriptions. Today there is no excuse for that, unless the pharmacist continues to be an automaton. The increased interest of the clinicians in the therapeutic possibilities of chemotherapy has engendered a new awareness of the responsibility and capability of the pharmacist and has brought about an appreciation of the contribution he makes toward the care of the patient.

Such interest in chemotherapy will be used by the alert pharmacist as an opening wedge in the new medico-pharmaceutical alliance. Once the physician learns that that young man or woman in charge of the pharmacy is not a noncommittal drug clerk but an intelligent individual, thoroughly conversant with the details of drug therapy, he will seize the opportunity to avail himself of the pharmacist as a consulting medium. He has long recognized the advantage of consultation with the pathologist, the roentgenologist and the biochemist. Now his storehouse of knowledge may be further enriched by contact with a newly discovered source of information and reference, the pharmacist.

Need we fear that the physician will be offended if he is expected to seek and receive advice from the pharmacy? Why should he resent the suggestion that he needs the consulting service of the pharmacy when he, despite his academic training in bacteriology and pathology, does not hesitate to consult the hospital's specialists in these fields?

The clever pharmacist will gain friends among members of the medical staff by making his reference library available to the doctors. This presupposes the fact that the pharmacist has accumulated up-to-the-minute and authoritative reference material that will be readily accessible. To find that the pharmacist can immediately put his fingers on the last word on a subject will awaken new respect on the part of his co-worker, the medical man.

In the Rôle of Consultant

The modern pharmacist is in a day-to-day contact with the application of the federal Food, Drug and Cosmetic Act and laws governing the dispensing of narcotics, poisons and alcohol. He, therefore, is in a position to render invaluable service to the doctor, who fast becomes dependent upon him for his knowledge in this specialized field. The doctor should not hesitate to call upon the pharmacist nor should the doctor, in turn, resent questions by the pharmacist as to the interpretation of a prescription submitted by the physician.

The pharmacist who assumes the rôle of consultant must know his subject and keep abreast of the times. Today, as never before, it is essential for him to be on the *qui vive* not only for new drugs but also for substitutes for many of the tried and tested ones that cannot now be purchased. It is in this enforced substitution for certain old favorites that the pharmacist can be of greatest help to the busy physician.

The bugbear of priorities and the inability to procure many drug supplies emphasize the importance of the pharmacist's possessing an investigative mind and a research "complex." He must probe into the efficiency of hitherto disregarded and untried drugs that now can be used in place of the so-called "old reliables." The doctor, too busy to do his own experimenting, needs the suggestion of the pharmacist to use an available product in place of an unavailable or priority-restricted one.

Confronting the Ogre of Cost

Where the ogre of cost comes into the picture, the pharmacist can often assist the physician by recommending a substitute that will result in a monetary saving to the patient. The physician can reciprocate by bearing in mind when he writes prescriptions the fact that medications selected for palatability and esthetic appeal should be reserved for the carriage trade, if the carriage trade wants to pay for the extra pampering. During these war days restricting prescriptions to the inexpensive equivalent is a patriotic duty.

Perhaps the most lucid demonstration of teamwork between pharmacy and medical staff is the establishment of a formulary prepared mutually by the pharmacist and the physicians. It need not be hidebound or restrictive but should, instead, serve as a medium to appraise the staff of the resources and contents of the pharmacy and encourage the use of official drugs and preparations listed in the National Formulary and the U. S. Pharmacopeia.

The advantages of a formulary may be summarized as follows:

1. It facilitates the writing and reading of prescriptions.

2. It makes for maximum dispensing in a minimum of time, as preparations may be prepared in advance in large quantities.

[2]Mod. Hosp. **57**:102 (Sept.) 1941.

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3. It eliminates unnecessary duplication in stocking products already on hand and tends to lessen the need for excessive stock.

4. It fosters adoption of the use of the less expensive equivalent, resulting in a savings in cost of medication both to the hospital and to the patient.

The hospital, however, must not assume a mandatory position in regard to the use of a formulary. If we want progress in our hospitals, we must allow leeway for research into new fields of drug therapy and not permit absolute conformance to the provisions of the formulary to throttle the desire for intensive study.

While the profligate use of the newest and most expensive fad is certainly not to be condoned, the physician's interest in changing trends in treatment and medications should not be stifled in the sweet name of dollars and cents economy. Indeed, the wide-awake hospital administrator, mindful of the fact that "research is the enemy of complacency," should encourage the physician who possesses an investigative mind to be constantly on the lookout for new trends in drug therapy.

Here especially can the pharmacist be helpful, particularly if he has done his stint of reading. His sagacious counsel may prevent the doctor's squandering time on a study already made, or his report on certain findings may prove an incentive to the doctor to delve into an interesting research problem.

It is the obligation of every department head to operate his department as efficiently and economically as possible. In the pharmacy where perhaps such efficiency and economy are controlled to a more marked degree than elsewhere by the whims and vagaries of the doctors, the pharmacist must lose no opportunity to educate the medical staff to intelligent appraisal of the service the pharmacy can render to both the physician and patient.

Help in Research

One of his best means of approach is to report at medical staff meetings the new drugs available in the hospital pharmacy and give a résumé of the latest developments in the field of pharmaceutical research. The staff members, too engrossed in their own professional duties to have time to ferret out this information, will eagerly accept it. Meanwhile, in the eyes of the grateful physician, the pharmacist will have grown in mental stature and will have earned the doctor's admiration and respect.

With a twinkle in his eye a pharmacist once gave me the following as his version of the requirements for a good pharmacist: "A pleasing personality, a ready smile, the ability to toss aside small irritations, a strong constitution coupled with a fairly weak mind."

This gentle indictment should make us hospital administrators fidget, that is, if we have been guilty of treating the pharmacist as though he had, in truth, been selected on the basis of possessing a back strong enough to handle alcohol drums and "a fairly weak" mind. How many of us have encouraged him to do creative work and to take his stellar rôle in the hospital constellation? Have we been too niggardly even to grant him time to mingle with his co-workers, the physicians? Have we given him an opportunity to exemplify the pharmacy slogan, "They must upward and onward who would keep abreast the pace."

Our dietitian recently delivered what she jocularly described as one of her better speeches to blundering bus boys. At the conclusion of her plea for their cooperation, rotund, jovial Tony, the pride of the bus boys' brigade, clicked his heels, squared his shoulders, threw back his head and, raising his shining black eyes heavenward, as though calling on the Deity to witness his pledge, solemnly avowed, "Tony co-op."

In the majority of our hospitals there is an able pharmacist who is eager to work with the physicians and to learn from them, if only he's given the opportunity to "co-op."

NOTES AND ABSTRACTS

Conducted by the Staff of the Pharmacology Department Wayne University, Detroit

Shock, Its Physiology and Treatment

The realities of warfare have again aroused intense interest in the causes and methods of treating shock. As in the last war, this remains one of the most important causes of death following wounds or burns. However, the designation "shock" is too broad to identify accurately the nature of the disturbances listed under this term and actually describes only the extreme prostration common to most forms. Such forms as "shell shock" and percussion shock involving primarily mechanisms other than those of the cardiovascular system will not be discussed here.

Physiology of Shock

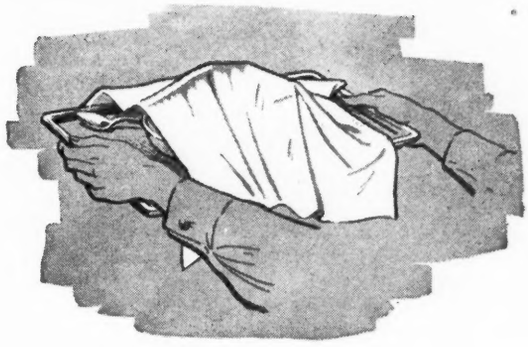
Shock, as used here, is divided into (1) hemorrhagic shock and (2) traumatic shock. Both are characterized by a decline in arterial pressure, rapid and feeble pulse, pallid skin and profound depression. However, here the similarity ends.

Hemorrhagic shock results primarily from a loss of circulating fluid in which the remaining portion shows dilution with a decreased hemoglobin concentration and a reduction in the number of red cells, reduction in specific gravity and changes in the concentration of inorganic constituents suggesting compensatory withdrawal of extravascular water into the vascular compartment. The permeability of the capillary remains unchanged, at least until just preceding death; pulmonary edema is absent, and there is no vomiting or diarrhea.

Inasmuch as the primary defect is in the volume of circulating whole blood, it is easily corrected by taking measures to stop the hemorrhage and by transfusion of compatible whole blood to replace that lost. At times the infusion of isotonic saline or glucose solutions is effective. Excessive hemorrhage with sustained hypotension may induce changes comparable to those characteristic of traumatic shock.

Similarly, hemorrhage associated with tissue damage may contribute to the induction of traumatic shock. In the latter condition there is an increase in capillary permeability, increase in the volume of tissue fluid, progressive pulmonary edema, disturbed fluid balance, impaired absorption from the tissue and gastro-intestinal tract, frequent vomiting, increased hemoglobin concentration, increased number of red cells, increased specific gravity and changes in the concentration of the inorganic constituents of plasma indicating the loss of blood water.

These are not corrected by blood transfusions and the condition of the patient is often not improved by the



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administration of saline solutions. Whereas, in the first instance, there is a loss of whole blood with a compensatory vasoconstriction and mobilization of cell water, in this case the picture is one of increased capillary permeability and filtration with the loss into the tissue of plasma and with it a resultant blood concentration.

The differences between hemorrhagic and traumatic shock have been pointed out by Doctor Moon of Philadelphia in a recent review article. He believes that the primary causative agent in the latter condition is a "traumatic toxemia." This could result from a toxic agent or agents released from damaged or dying tissues. The sequence of events following injury are: (1) capillary atony, with increased permeability of the capillary endothelium leading to deranged fluid balance, blood concentration, congestion, petechiae, stasis, edema and effusion; (2) reduced blood volume; (3) reduced volume flow; (4) reduced delivery of oxygen; (5) tissue anoxia; (6) further production of toxic agents.

This constitutes a vicious cycle in which the anoxia as a terminal change initiates a further elaboration of the toxic causative agent.

Bank Blood

Recent years have seen the introduction into practice of various new procedures for restoring the circulating volume. Of particular interest is the use of stored whole blood. This practice had its origin among Russian physicians who were the first to make use of cadaver blood for transfusion. They showed that this could be preserved for considerable periods of time and still retain its original physical and physiologic properties and, therefore, that it could be used successfully for transfusion.

This aroused considerable interest and provoked similar research in other countries. Doctor Denstedt and associates at Montreal have studied the survival of red cells after transfusion when the transfused blood had been stored for periods of time up to two months. They found that citrated blood may be stored at a temperature of 4° C. for up to eighteen days without any adverse effects on the time of survival of the erythrocytes in the circulation of the recipient. They are further of the opinion that with twenty-five or thirty day old blood, cell survival after transfusion is sufficiently long during the first three weeks to warrant the use of such specimens in the treatment of severe blood loss if no other blood is available. Some of the transfused cells were found to survive in the circulation of the recipient for more than sixty days.

A readily available supply of typed, refrigerated blood reduces the delay in making transfusions and should become a standard part of the hospitals' armamentarium.

Plasma

The recent development and use of pooled plasma are of equal interest. Recent developments have provided this important agent as preserved plasma, frozen plasma or in the dry state. Plasma was extensively used in the treatment of war injuries following the attack on Pearl Harbor. Results reported indicate that it was most effective in the treatment of shock. Subsequently, it has had wide use with relatively few reports of reactions. Reactions have been reported so infrequently that their occurrence is probably due to nonspecific agents. The use of pooled plasma made up from all blood types indicates that the presence of the various iso-agglutinins suppresses the activity of each iso-agglutinin.

Pectin

The search for blood substitutes continues and has been accelerated by the war. Previous experience with solutions employing gum acacia has not been satisfactory because of the variability of

various batches of gum, because of hemolysis, agglutination and increased sedimentation rate and because of liver damage.

Of more interest have been the efforts of various laboratories to develop suitable pectin solutions for infusion. Doctor Hartman of Detroit has described the successful use of pectin solution in the management of shock. The material used in these experiments was obtained from citrus fruit and was infused as a 1 per cent sterile isotonic solution having a viscosity and colloid osmotic pressure approximately equal to that of blood plasma.

This material was reported to be nonantigenic and nontoxic. It was retained in the body for only a comparatively short time, produced no demonstrable change other than an increased sedimentation rate and apparently caused no liver damage.

Following massive doses of pectin solution, there was only slight reduction in liver function as measured by the fractional bromsulphalein test. The rise in blood pressure following infusion of pectin solution was well sustained and the general condition of the patient improved steadily in the immediate postinfusion period.

Doctor Kozoll and associates in Chicago have administered pectin solution to human beings not in shock. They found this an effective means of producing blood dilution and that the diluting effect was much more marked and better sustained than either isotonic dextrose or saline solutions. However, they, too, found an increase in the sedimentation rate, resulting from rouleau formation, but did not feel that this should necessarily cause a rejection of pectin solutions. It is pointed out that the resulting sedimentation velocity is not in excess of that commonly found in infections.

Several attempts have been made to use gelatin but with indifferent success. Ordinary gelatin is reported to have definite antigenic properties and some difficulty has been encountered in its purification. Fish gelatin, prepared from fish swimming bladders, has been used in animal experiments with some success.

Several attempts to use plasma other than human have also been made but, in general, have been found unsuited because of a danger of initiating foreign protein reactions.

Summary

The choice of the therapeutic agent should be determined by the physiologic need of the particular situation. When loss of blood and blood dilution are the primary findings, transfused whole blood or bank blood should be used, if possible. Lacking these, plasma or pectin may be used to aid in sustaining pressure until a blood transfusion can be arranged or, in case of moderate hemorrhage, may be effective in preventing shock without transfusion of whole blood.

Isotonic saline solution or glucose solution is least desirable inasmuch as neither remains for long in the circulation. In traumatic shock the characteristic feature is a loss of circulating plasma, the red cells being for the most part retained.

Plasma is the logical agent and has been found most effective. Doctor Necheles of Chicago has pointed out the enormous amounts of plasma required to maintain blood volume after extensive burns. He reports that the amounts of human serum infused during the first twenty-four hours of treatment were often in excess of the total estimated blood volume of these patients.

Pectin solutions have been prepared with viscosities and colloid osmotic pressures similar to that of blood plasma. Experimental work indicates that these solutions are nontoxic and may be used as a plasma substitute if the latter is not available.—A. M. Lands, Ph.D.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

A Study of Hospital Admissions

A group of persons living in the eastern health district of Baltimore was studied in an attempt to ascertain the extent of their use of hospital facilities over a ten year period. The hospitals in which the population was traced were chosen because of their relative importance in serving this district. The nine hospitals included slightly more than 80 per cent of the total number of admissions to all institutions from the 9479 district residents hospitalized.

The data published by Clara E. Councell in her article, "Past Hospital Experience of a Surviving Population, Eastern Health District, Baltimore, 1926-1935," in the *American Journal of Hygiene* for July 1943, indicated that about one fifth of the people who had survived over the ten year period studied had one or more admissions to the nine hospitals from which records were obtained. These persons spent an annual average of 400 days in the hospital per thousand population.

Surgical cases were about twice as numerous as nonsurgical, but the nonsurgical remained in the hospital a greater number of days.

The most frequent causes of admission were tonsillectomies and adenoidectomies, deliveries of live births, appendicitis, nonvenereal diseases of the female genital organs and fractures.

Of the people under observation for a complete ten year period, excluding children under 10 years of age, 79 per cent had no admission to a hospital; 16 per cent had one admission; 3 per cent had two admissions; 1 per cent had three admissions, and 1 per cent had four admissions or more.

This picture of morbidity must be considered in the light of the following facts: (1) institutions for the care of tuberculosis and mental diseases were not searched; (2) the hospitals studied were within or contiguous to the district from which the population was traced, and (3) the financial circumstances of the population.—SIGMUND L. FRIEDMAN, M.D.

Using the Ophthalmoscope

The discovery of the ophthalmoscope opened to physicians a laboratory in which the clinician can objectively study many pathological processes with an accuracy previously equaled only by the pathologist. For what the physician sees here is but an index of what is taking place, hidden from view, elsewhere in the body. The general circulation can, for example, be studied by means of the ophthalmoscope, for the circulation of the eye is governed by the same anatomic and physiological rules that govern the distribution of blood to every body organ.

One of the earliest signs of hypertension is constriction in the caliber of the small arteries of the eye and recognition of these early pathological changes is taught to every medical student.

A. M. Ramsay, in an article, "The Ophthalmoscope in Clinical Medicine," in the *British Medical Journal* for June 5, 1943, also stresses the importance of hemorrhage from the retinal blood vessels. Its cause, he points out, must be investigated as thoroughly as that of hemoptysis or hematemesis.

These observations cannot be properly evaluated unless they are correlated with the general disease picture.

Doctor Ramsay makes the extremely important point that the physician should learn to examine the eye with the ophthalmoscope as habitually as he feels the pulse and examines the heart and lungs.—SIGMUND L. FRIEDMAN, M.D.

NEWS IN REVIEW

870 Nursing Schools Allotted Funds Under Cadet Corps Program

WASHINGTON, D. C.—Federal funds for the U. S. Cadet Nurse Corps program had been allotted to 870 schools of nursing by October 12, according to an announcement by Lucile Petry, director, division of nurse education, U. S. Public Health Service. More than 1000 schools have applied and more applications are being approved daily.

Many of the schools whose applications have not yet been approved fail to supply complete information in reply to second, third and fourth letters of inquiry, Miss Petry stated.

The 870 participating schools have estimated that a total of 84,710 students, including those already in training, as well as 41,156 new recruits, would be enrolled in the corps during the year.

The number of applications approved and pending by states as of October 12 is shown in the next column:

State	Approved	Pending
Alabama	12	6
Arizona	4	0
Arkansas	3	2
California	28	1
Colorado	10	0
Connecticut	13	2
Delaware	5	1
District of Columbia	6	0
Florida	7	3
Georgia	13	0
Idaho	4	1
Illinois	73	11
Indiana	19	4
Iowa	19	1
Kansas	26	3
Kentucky	13	2
Louisiana	14	0
Maine	4	6
Maryland	13	1
Massachusetts	38	4
Michigan	21	3
Minnesota	22	3
Mississippi	0	4
Missouri	20	3
Montana	6	0
Nebraska	8	0
New Hampshire	7	2
New Jersey	36	0
New Mexico	1	0
New York	79	7
North Carolina	23	7
North Dakota	11	3
Ohio	52	6
Oklahoma	8	4
Oregon	8	2
Pennsylvania	94	9
Rhode Island	4	2
South Carolina	6	10
South Dakota	9	1
Tennessee	12	1
Texas	32	3
Utah	5	1
Vermont	3	4
Virginia	26	1
Washington	20	1
West Virginia	13	6
Wisconsin	18	2
Wyoming	0	0
Hawaii	0	0
Puerto Rico	2	0
Totals	870	133

Slack Suits for Army Nurses

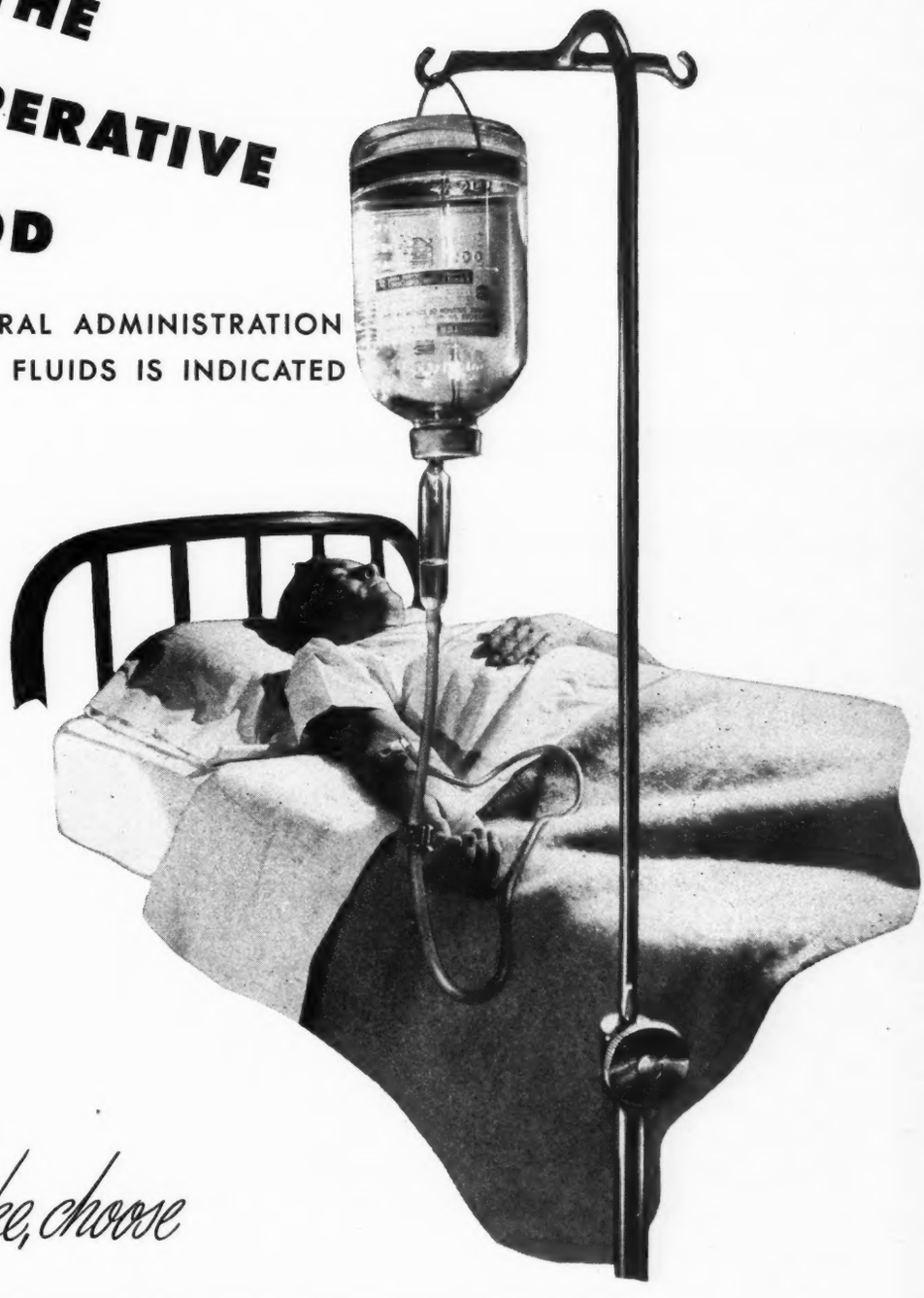
Army nurses on duty on hospital ships and trains and doing active physical work overseas will wear the new two-piece slack suit of brown and white seersucker designed for them by the Quartermaster Corps. The tailored shirt has long sleeves, a convertible collar that can be worn either buttoned or open and a pleated yoke permitting freedom of shoulder action. The slacks are also tailored, with one side pocket and a slide fastener closing. Experience has shown that the slacks are more practical than a skirt or dress type of uniform for many types of work.

Navy Nurses Get Instruction

A class of 20 Navy nurses arrived at George Washington University to begin a course of instruction in dietetics, the office of Capt. Sue Dauser, superintendent, Navy Nurse Corps, announced September 30. Starting a four month course in psychiatry at St. Elizabeth's Hospital were 10 Navy nurses.

FOR THE POST-OPERATIVE PERIOD

WHEN THE PARENTERAL ADMINISTRATION OF FLUIDS IS INDICATED



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Addition to Kaiser Hospital Approved by Federal Works Agency

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—To provide urgently needed hospital facilities in the war-worker congested area of Oakland, Calif., the Federal Works Agency will construct a 120 to 160 bed addition to Henry J. Kaiser's Permanente Foundation Hospital, Maj. Gen. Philip B. Fleming, F.W.A. administrator, announced September 27. F.W.A. will finance the hospital addition, the estimated cost of which is $1,200,000. Included in the cost are acquisition of land and purchase of equipment. President Roosevelt has approved the allotment of funds under the Lanham Act.

The addition will provide hospital facilities for the general public, including employes of the Kaiser Shipyards and employes of other war plants. The addition will be operated by the foundation for twenty years at an annual rental of approximately one twentieth of its cost. The lease will give the Permanente Foundation an option to purchase the structure at any time after six months following declaration by the President of the termination of the war emergency. Rental already paid would apply against the purchase price.

Another announcement, September 25, by F.W.A. revealed the proposed construction of hospital facilities at Sylacauga, Ala. The estimated cost is $517,303.73; proposed financing, federal construction, $11,583.73; grant, $306,639; loan, $175,000; government field expense, $24,082. It is proposed to construct and equip a three story and basement hospital building of 82 bed capacity.

Further construction of hospital facilities was announced October 6 by F.W.A. as follows:

Los Angeles, applicant, Lutheran Hospital Society of Southern California, alterations, additions and the construction of a one story service building, together with the furnishing of equipment to provide 102 beds to an existing hospital, to cost $124,710.

Des Moines, Ia., applicant, Iowa State Department of Health, renovation and remodeling of an abandoned hospital building, including expendable equipment, to provide facilities for a rapid treatment center and detention home for venereal disease patients, to cost an estimated $35,174.

Las Vegas, Nev., applicant, Clark County, construction of a new hospital building having a normal capacity of 81 beds and the reconstruction of an existing building to provide nurses' quarters and a detached contagious ward, containing 6 beds, a morgue and storerooms, also additional furnishings and equipment, to cost an estimated $507,585.

"Conserve" Is Slogan for Fuel Consumers, Ickes Warns

WASHINGTON, D. C.—Every coal consumer will find it necessary to cut his usual fuel consumption during the forthcoming season to ensure enough coal for war industries, to avoid personal discomfort and to provide for possible shipments to the Army in liberated territories, Harold L. Ickes, Solid Fuels Administrator, stated recently.

"There are many definite ways by which coal can be saved," Mr. Ickes said, "and if every consumer will constitute himself a conservation committee of one we may have enough coal to operate all our plants, send what is needed to our armies in conquered lands and at the same time avoid any actual distress because of lack of fuel."

A fuel efficiency program to combat wasteful practices in the use of coal, coke, wood, petroleum and gas is being launched by Mr. Ickes. Emphasis will be placed first on commercial and industrial plants.

The mounting scarcity of coal, said an official of the fuel rationing division, O.P.A., in an interview October 15, has affected the conversion program. If an institution, he said, had converted from oil to coal under the policy followed last winter and now wished to reconvert to oil, it would be necessary to apply to P.A.W. for special authorization to do so.

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FARADAY Ward Bedside Station with Single Cord, Plug and Locking button. Cat. No. 1905

Nurses' Calling Systems

These efficient, constant duty units are designed to be readily adaptable to modern decorative treatments. Architects and engineers specify them for existing buildings as well as for new structures, because installation is quick and easy. Although of highest quality and dependability, these units are economical in cost.

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Ward Bedside Stations

Locking Button, Pull Cord Type. For complete descriptions of all hospital signals and signal systems, send for Stanley - Patterson - Faraday Hospital Signals Catalog Section.

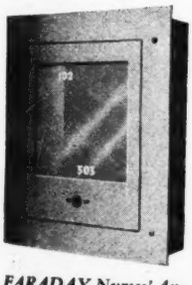
Emergency Service

Stanley-Patterson-Faraday Ward Bedside Stations may be equipped with an additional button, which permits the operation of the emergency red light at both the utility and duty stations, in addition to the annunciator and cord or dome stations.

FARADAY Corridor Dome Station Cat. No. 2050

Corridor Dome Stations

Stanley - Patterson - Faraday Corridor Dome Stations are door-type for easy and instant servicing of bulbs. Tight fitting jackets prevent light leakage. Non-glare globes give soft light.



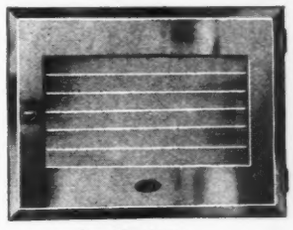
FARADAY Nurses' Annunciator Cat. No. 2070

Annunciators

Nurses' Annunciators are designed for maximum readability and accessibility. Number panels are of gleaming white translucent easy-to-clean material. No light leakage between numerals. Door hinges concealed. Furnished with mild tone buzzer calling attention to each new call as made, to prevent repetition of service if board is uncleared.

Night Lights

Made in different types for various requirements, including dome and Louvre type. Hinged doors have silent latch for maximum accessibility and ease of servicing.



(Right) FARADAY Louvre-Type Night Light—with horizontal Face Plate Cat. No. 2154

Doctors' Paging Systems

Calls for doctors as received by operator, are quickly signaled through the hospital with Stanley-Patterson-Faraday Paging Systems. Key on operator's switch box controls corresponding number on every Paging Annunciator. As many as three calls can be made simultaneously. Canceling of one or more does not affect others. Auxiliary mellowtone single stroke chime may be used in conjunction.

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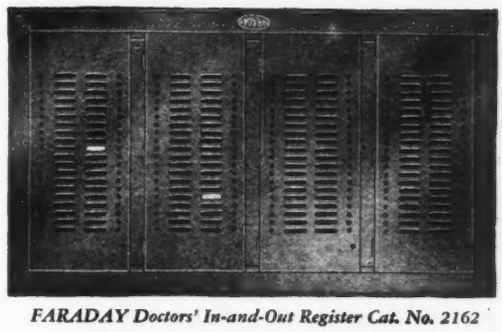
Constructed in panel units up to 40 names each. Names stand out clearly against translucent background. Individual toggle-switch controls lighting for each name. Panel face plates hinged for insertion of names and servicing of lights. Each panel unit may be easily expanded to any desired number of sections.



FARADAY Doctors' In-and-Out Register Cat. No. 2162

New Hospital Signals Catalog Now In Preparation

As an additional service to hospital managements, architects and builders, a completely new and detailed illustrated catalog of Stanley-Patterson-Faraday Hospital Signals and Systems is now in production. Send your name for mailing of this helpful catalog as soon as received from the printer.

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Danger of Attack Not Over Until Last Day of War, Says O.C.D. Chief

WASHINGTON, D. C.—Thoughtless or calculatingly subversive rumors that civilian defense is unnecessary have recently been spread by irresponsible persons, said Dr. George Baehr, Chief Medical Officer, O.C.D., in instructions October 1 to regional medical, nursing, gas and rescue officers.

In the opinion of the best military authorities our coastal areas and industrial centers will not be free of the danger of enemy attack from the air or of widespread sabotage until the last day of the war, Doctor Baehr declared.

Civilian defense is needed also as one of the essential measures for safeguarding internal security, the Chief Medical Officer continued. This is especially true of the Emergency Medical Service. If we had not created a nation-wide organization for civilian defense two years ago, we would be obliged to organize one today for home security.

Disasters of all kinds have increased because of the tremendous speeding up of our great industries, the overburdening of our railroads and the inexperience of hundreds of thousands of new war workers, Doctor Baehr pointed out. Our police, fire departments, public works and utility services and hospitals are being increasingly depleted of trained personnel. Therefore, we must strengthen our voluntary protective services throughout the land.

Three tragic incidents—the Congressional Limited and the Twentieth Century train wrecks and the Houston Hotel fire — in widely separated parts of the country in less than twelve hours demonstrated the day-by-day value of the trained organization, James M. Landis, former director of O.C.D., pointed out in a recent statement. In two of these emergencies, lives were saved and suffering relieved by the prompt action of civilian defense rescue squads, Emergency Medical Service and other trained protection units, and by the immediate availability of civilian defense ambulances, blood plasma, stretchers and medical supplies.

More Money for Maternity Care for Servicemen's Wives

WASHINGTON, D. C.—With the signing by President Roosevelt on September 30 of the $18,620,000 deficiency bill providing extra funds to the Children's Bureau, more than 200,000 additional wives and babies of servicemen will be able to receive maternity and infant care during the remainder of this fiscal year.

Cooperating to date in the program are 44 states, the District of Columbia, Alaska and Hawaii. Of the remaining four states, Colorado and Texas are at present working out plans; Louisiana and North Dakota have so far failed to submit plans.

Cases of some 50,000 wives and babies of servicemen have been authorized for care between the time the first state, North Carolina, joined the program on April 8 and September 1. At the present rate, it is estimated that for the months still left of the fiscal year care will be requested for from 20,000 to 25,000 cases monthly.

An amendment passed with the deficiency appropriation limits the program to wives and infants of enlisted men in the four lowest pay grades. Wives and infants of servicemen in the top three grades below commissioned officers are now barred.

Use of Butter Substitutes Approved

Pennsylvania hospitals have been notified by the state department of agriculture that they may purchase butter substitutes or oleomargarine "without fear of reproachment by the State Department of Agriculture, pending an adoption of a system to handle such requests."

In the Diet of the Hospitalized Patient

Cereal breakfast foods merit an important place in hospital dietetics. When the diet is "normal," they present good nutritional value and permit of attractive, appetizing variation in the morning meal. In specialized diets, especially G. I. and post-surgical, they afford advantages justifying their inclusion in the evening meal as well as in the breakfast.

Nutritionally, breakfast cereals —whole-grain, or enriched or restored to whole-grain values for vitamins and minerals—contribute to several essential needs. Their protein content shows an average of 10 per cent (from 7% to 14%, depending on the grain source); their protein is highly acceptable to the human organism, contributing to growth as well as maintenance.

When one ounce of cereal—either prepared or its equivalent in cereals to be cooked—is served with four ounces of milk and one teaspoonful of sugar, this palatable dish provides about 7 Gm. of protein, biologically adequate because of the contained milk, 33 Gm. of carbohydrate, and 5 Gm. of fat, approx. 205 calories. In addition, it contributes appreciable amounts of B-complex vitamins, iron, calcium, and phosphorus.

The fiber content of most cereal breakfast foods is notably low—an average of 1.3 per cent. Hence they are dependably bland and easily digested, permitting early inclusion in the post-surgical diet, almost as soon as liquids are retained. In the diet of the gastrointestinal patient, their nutrient value, their blandness, their contribution to B-vitamin and mineral requirements, and their wide variety of taste and form make them especially advantageous.

The presence of this seal indicates that all nutritional statements in this advertisement have been found acceptable by the Council on Foods and Nutrition of the American Medical Association.

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Nurses' Salaries in California Stabilized at $155 Minimum

WASHINGTON, D. C. — Publication of the tenth regional War Labor Board's decision regarding nursing salaries in California was delayed for some reason and copies were not available in the *Bureau of National Affairs Daily Report* until October 5, although the decision was dated September 3.

As a result of delayed access to the official statement, a news story in the October MODERN HOSPITAL was based on an earlier release from the Association of California Hospitals. This release was correct when written but had been made out of date by the later decision.

The minimum monthly entrance salary for general staff nurses throughout California is now set by W.L.B. at $155 with a $2.50 increase each six months to a maximum of $170, not at $140 to $155 as previously set by W.L.B.

Surgical, obstetrical and communicable disease nurses and nurse anesthetists have a scale of $165 to $180 a month and industrial nurses in the San Francisco Bay area have a minimum of $155 with a credit of $2.50 a month for each six months of experience after certification as a registered nurse up to a maximum of $190.

The War Labor Board excluded nonprofit hospitals within the tenth region from the exemptions provided in General Order No. 26 in order to stabilize nurses' salaries.

Walter and Baehr Name New Volunteers' Committee

WASHINGTON, D. C.—Approximately 12,000 local Civilian Defense Councils were recently instructed to cooperate with hospitals in every community in building up a corps of male volunteers for service in hospitals to meet the present urgent personnel shortages.

A memorandum, prepared by a joint committee of the medical division of O.C.D. and the American Hospital Association, was sent to A.H.A. institutional members on October 15.

The joint committee, appointed by Frank J. Walter, A.H.A. president, and Dr. George Baehr, Chief Medical Officer of O.C.D., consists of Oliver G. Pratt, chairman, Salem Hospital, Salem, Mass.; Frederick D. Grave, director of the men's volunteer corps, New Haven Hospital, New Haven, Conn.; Ralph Couch, superintendent, University of Oregon Medical School Hospitals and Clinics, Portland; Dr. Jack Masur, hospital administration specialist, medical division, O.C.D.; Dr. R. C. Buerki, director, Hospitals of the University of Pennsylvania, Philadelphia, and Marian G. Randall, chief nurse, medical division, O.C.D.

The memorandum recommends that hospitals proceed as follows: (1) determine what tasks men volunteers can assume; (2) arrange suitable work schedules, particularly for evening and night shifts; (3) obtain the assistance of the local O.C.D. volunteer office in recruiting volunteers; and (4) arrange for proper selection, training, organization and supervision of the men volunteers.

Naval Convalescent Hospitals in West Seen by Inspector

WASHINGTON, D. C.—An inspection of all naval convalescent hospitals located in the west and southwest parts of the country has been made by R.A. Luther Sheldon Jr., assistant chief, Bureau of Medicine and Surgery, U.S.N., and Comdr. F. J. Braceland, Medical Corps, U.S.N.R. Included were hospitals at Glenwood Springs, Colo.; Sun Valley, Idaho, and Santa Cruz and Yosemite National Park, Calif.

That the Navy's medical department is in a position to handle satisfactorily any burden that may be thrown upon it by reason of the war in the Pacific was Admiral Sheldon's conclusion as a result of the inspection trip.

OFFICIAL ORDERS

September 15 to October 15

Construction.—Existing restrictions on construction of new facilities will be continued and facilities under construction will be reduced to the minimum necessary to the war program and for essential civilian needs, W.P.B. announced October 15. The directive for war-time construction dated May 20, 1942, was specifically confirmed.

Copper Wire.—Retailers and others who sell copper wire may purchase limited quantities and sell it to the public without restriction under CMP Regulation No. 9, issued September 10. In selling copper wire under the new regulation, retailers need pay no attention to any preference rating other than AAA or a farmer's certificate under Priorities Regulation No. 19. Hospitals may still use AA-1 under CMP-5A, if the supplier demands it.

Diapers.—Recent increases in manufacturers' ceiling prices of standard gauze diapers do not affect the ceiling prices of wholesalers or retailers, O.P.A. announced October 8.

Freon.—If hospitals have trouble getting freon through regular channels, they can then wire the refrigeration section, General Industries Equipment Division, W.P.B., Washington, D. C., said an official of the hospital unit in an interview on October 14. W.P.B. has tightened control over freon in some respects.

Conservation Order M-28, as amended September 8, requires users to certify that it is needed for immediate use, rather than during the following thirty days as formerly permitted. William Brines, chief of the hospital section, W.P.B., said, however, that where the continuous operation of blood plasma units is to be safeguarded, exception is made for hospitals and a reasonable supply may be held for servicing.

Ice Refrigerators.—There is a good supply of domestic ice refrigerators, William Brines says, and in the face of the scarcity of electric refrigerators, hospitals should buy them instead of trying to get mechanical ones. Approximately 230,000 will be manufactured in the fourth quarter of 1943, through issuance on October 7 of Schedule V of Order L-7-c.

Ipecac.—Ipecac and its derivative, emetine, were placed under allocation by W.P.B. on September 29 through issuance of Order M-350, effective November 1. Exempt from authorization by W.P.B. is delivery by any person to any other person for compounding into standard dosage forms for medicinal purposes pursuant to toll agreement.

Laboratory Equipment.—Control over the distribution of laboratory equipment has been eased through issuance of an amendment issued October 9 to Order L-144. Laboratory equipment and supplies are now available without authorization, interpreted William S. Brines, with the exception of the 11 items in List A of the order and then only when these items individually have a value of $50 or more. These items are: analytical balances; calorimeters; centrifuges; hydrogen ion meters (electrometric); metallo-scopes; microscopes (except brinell and tool makers); microtomes; potentiometers, wheat-stone bridges and resistance boxes; refractometers; spectrographs, spectroscopes, spectrometers and spectrophotometers; vacuum pumps (micron or higher vacuum). Such equipment as incubators, water baths, pipettes and glassware in general is available without application, Mr. Brines said, because hospitals are expected to conserve voluntarily. The amended order also puts Canadian distributors on the same basis as U. S. distributors, removes several items from List A and makes clear that List A does not include second-hand equipment or parts for maintenance or repair of existing equipment.

Medical and Surgical Furniture.—Restrictions on the use of metals in this equipment were eased slightly October 9 by Schedule 3 of Order L-214, as amended. More plating is permitted and changes are made in the permitted use of metals and the number of permitted models. Six items are deleted from the schedule since they are adequately restricted by M-126. They are book trucks, dish trucks, laundry trucks, linen hampers, linen trucks and shelf trucks.

Paper Products.—Unrestricted production of paper embalming, surgical and obstetric sheets, hospital wadding, surgical bandages, surgical masks and caps and other products is permitted by Order M-241-a, as amended October 5. Toilet tissue, towels, facial tissue, napkins, slippers and many other products may be manufactured at 100 or 110 per cent of the 1942 level.

Penicillin.—A total output of 150,000,000 units of penicillin by next July 1 was set as a goal at a meeting of the penicillin producers industry advisory committee with the W.P.B. and other federal officials on September 26. Representatives of 17 companies attended.

Photographic and Projection Equipment.—Production and distribution of this equipment, accessories and parts were brought under restrictive controls through the issuance of Order L-267 on September 20. All production and distribution of restricted equipment and accessories will be subject to specific W.P.B. approval. Special consideration will be given to the needs of governmental agencies, war plants, hospitals, physicians, medical technicians, educational institutions and printing and publishing industries. Restricted equipment includes any of the following when containing critical materials, except in joining hardware: still cameras, except aerial; motion picture cameras, except gun sight aiming point; motion picture projectors, except 35 mm.; still projectors and enlargers. It does not include equipment covered by the orders on office machinery, x-ray equipment or printing and publishing machinery, parts and supplies.

Restricted accessories include any of the following when containing critical materials except in joining hardware: camera accessories; 16 mm. and 8 mm. projection accessories; 35 mm. reels and cams; darkroom and studio accessories; photographic lenses in mounts; photographic shutters for still cameras other than built-in shutters, and photographic carrying cases.

Pipe Cleaners.—Pipe cleaners may be produced out of scrap wire by W.P.B. amendment to order M-126, September 14. Production will be sufficient for hospitals using pipe cleaners to clean trachea tubes and the like.

Reagent Chemicals.—Order P-135, which formerly assigned a blanket rating of AA-2X to reagent chemicals for laboratories, was amended September 28 for reassignment of ratings. AA-1 is assigned to deliveries of any reagent chemical to any laboratory having a serial number under P-43, and to any Army or Navy laboratory.

Special apparatus has been developed at the Hudnut Institute for Dermatological Research to study preparation of emulsions and viscosity

Behavior Patterns for Cosmetics

Every physician will concede that new developments in the scientific field should be guided to the fullest extent by the light of previous research on a given subject.

This principle is given practical application at the Hudnut Institute for Dermatological Research, where one department devotes the major part of its time to studying the chemical and physical properties of established products, subjecting them to tests and analyses which help form a behavior pattern for a given product.

Of special interest, perhaps, is the attention given the preparation and viscosity of emulsions, for which special apparatus has been developed. The importance attached to this phase of cosmetic research has been vindicated by the fact that many products developed by the cosmetic industry are now used by the medical profession in pharmaceutical preparations for the skin.

The Institute also maintains continuous study of wetting agents and their effect upon surface tension, a pertinent project in view of new developments in both cosmetic and therapeutic use of creams and lotions. Other important studies are being carried on by the Institute in related fields.

Our findings and services are at the disposal of any physician who wishes to avail himself of them. Complete information about the Institute is available, free, in booklet form. Address your request, please, to: Hudnut Institute for Dermatological Research, 113 West 18th Street, New York, N. Y.

RICHARD HUDNUT

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AA-2 is assigned to deliveries of any reagent chemical to any laboratory lacking a serial number under P-43 or to a distributor or producer of reagent chemicals. P-135-a was amended to exempt from certification the delivery or acceptance of delivery by a laboratory of not more than 10 per cent of the quantity of reagent chemicals in any period which are exempt from specific authorization under the small order clause.

Zinc Products—Zinc or zinc products cannot be used in the manufacture of any health supplies except the following items, according to order M 11-b as amended September 29: dental instruments, apparatus and equipment; dental supplies and appliances; lamps, health electric; medicinal chemicals; ophthalmic products and instruments; physiotherapy products, electrical; surgical and medical instruments, equipment and supplies; orthopedic appliances; x-ray apparatus and tubes; Class I and II garments, as defined by Order L-90; waterproof sheeting for hospital beds and hospital hampers and infants' crib sheets; hearing aids. Products not specifically prohibited by List A can use 60 per cent as much zinc as they used in 1941.

Army to Buy More Drugs but Less Equipment in 1944

WASHINGTON, D. C.—The Army Medical Department's procurement plan for 1943 calls for the purchase of $449,000,000 worth of drugs, chemicals, field equipment, hospital equipment and similar classifications, a spokesman for the Office of the Surgeon General announces. It is anticipated that the total for 1944 will be $353,000,000.

Although an over-all decrease of $96,000,000 is shown, more drugs, chemicals and biologicals will be needed next year than this, the official declared.

An illustration of the increased need for drugs in 1944 is provided by the figures on gas gangrene, with 1943 treatment requirements set at $2,250,000 as against 1944's estimated need of $4,250,000.

More fighting means more casualties. Blood plasma requirements in 1943 are 2,700,000 units; in 1944, the need has been set for 3,250,000 units. For penicillin, the expectation for 1943 is 125,000 to 200,000 ampoules; in 1944, the supply must be ten times that amount.

In the equipment and appliances field, there will be a sharp drop in buying. As against the expectation of $15,000,000 worth of x-ray equipment for 1943, the 1944 need will be for some $8,250,000 worth. The same reduced ratio will be maintained in the case of surgical appliances, the 1943 figure at $31,000,000, the 1944 at $15,300,000. The surgical dressing needs dip from $22,000,000 in 1943 to $17,700,000 in 1944.

18 States Top Nurse Quotas

WASHINGTON, D. C.—Eighteen states have oversubscribed their quotas of qualified nurses, according to figures released October 1, announced Gertrude Banfield, assistant director, Red Cross Nursing Service, in charge of recruitment. The states which have oversubscribed are: Alabama, Arkansas, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, Mississippi, Nebraska, Nevada, New Mexico, Oklahoma, Tennessee, Texas, West Virginia, Wisconsin and the territorial possessions. Among those states that have procured less than half their quotas are: Arizona, California, Connecticut, District of Columbia, New York and Vermont. Of the entire quota of 28,000 nurses, 32 per cent is yet to be assigned according to the October 1 figures.

Negro Consultant Appointed

WASHINGTON, D. C.—Rita Miller has been appointed consultant on Negro nurse education in the Division of Nurse Education, U.S.P.H.S. Miss Miller is on loan from Dillard University, New Orleans, where she is chairman of the division of nursing. Cooperating with Miss Miller in her work for the corps will be Mrs. Estelle Massey Riddle, consultant on Negro nursing, National Nursing Council for War Service.

Courses for Medical Librarians

Special courses for training in hospital and medical librarianship will be offered by the University of Minnesota division of library instruction during the spring quarter, according to a recent announcement. A six weeks' internship follows the courses. Information is available from the director of the division.

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U.S.I. PURE ALCOHOL ANTISEPTIC VEHICLE REAGENT

Partner in Medical Progress

North and South America Exchange Medical Knowledge

WASHINGTON, D. C.—More than 100 doctors from Latin America have come to the United States for additional training in public health work and some 30 United States physicians have already completed training in tropical disease control in Central America, according to a statement prepared on October 6 for The MODERN HOSPITAL by John M. Robey of the Office of the Coordinator of Inter-American Affairs.

This is part of a great inter-American health and sanitation program now under way in 17 of the other American republics. The United States contributes technical and financial assistance, through the Institute of Inter-American Affairs, in a continental effort to control malaria, tuberculosis, yaws and other diseases.

Dr. Eugene P. Campbell of the institute reports that medical men from the United States are enthusiastic about the training they are receiving in the republics to the south. Doctor Campbell is director of the missions assisting Costa Rica, El Salvador, Guatemala, Honduras and Nicaragua.

The training program was established by the Association of American Medical Colleges with financial support from the Markel Foundation in New York.

North American physicians in the plan spend three weeks in hospitals working on tropical diseases and then spend a week or ten days working with a field party.

Field Staff Embarks on Nurse Recruitment Campaign in Colleges

Full information about the U. S. Cadet Nurse Corps was presented at an institute held in New York on October 1 and 2 for the benefit of a college field staff that is being sent out to interest college women in preparation for post-war careers in nursing.

The field staff consists of 33 nurses who have teaching, administrative or executive experience who have been released by their respective institutions on short-term leaves to confer with deans of women, faculty members and students and to present the opportunities in the nursing profession.

This program of education and recruitment of college women has been undertaken at the request of Surgeon General Thomas Parran, U. S. Public Health Service, who administers the cadet corps. The schedule of the field staff for October, November and December includes visits to about 400 colleges and junior colleges.

Sugar Ration to Be Increased

WASHINGTON, D. C.—Increases in the November-December sugar allowances of institutional users normally doing their own baking were announced October 15 by Walter F. Straub, newly appointed director of the Food Rationing Division of the O.P.A. This action affects Group II and Group III. The larger classification, Group III, includes most hospitals. Group II institutional users, consisting of state hospitals, hospitals for the mentally ill, jails, prisons and other institutions of involuntary confinement, now receive an allotment of .03 pounds per person served. The increase is to .04 pounds per person served.

Hospitals Will Get Milk

WASHINGTON, D. C.—William S. Brines, chief of the hospital section, W.P.B., said in an interview October 14 that W.F.A. officials are reassuring concerning the milk and cream supply for hospitals. Several inquiries had come in to him, said Mr. Brines, and some hospitals had expressed concern over the possible curtailment of milk supplies. The hospital section is keeping in touch with W.F.A. officials who state it is their intention that hospitals will not suffer in the milk stabilization program.

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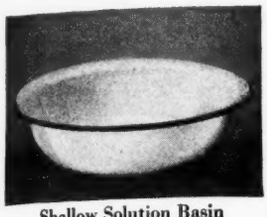
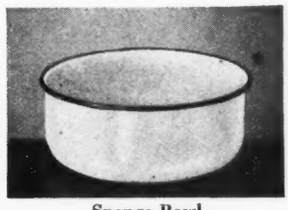
ITEMS COVERED BY ORDER L-214

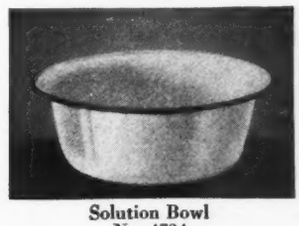


Shallow Solution Basin
No. 4711

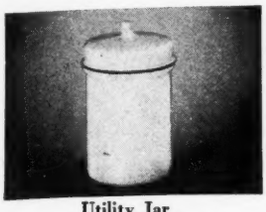
Pus Basin
No. 4860



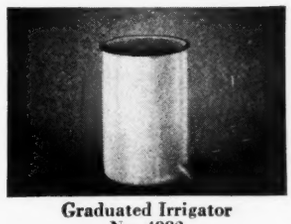
Sponge Bowl
No. 4741



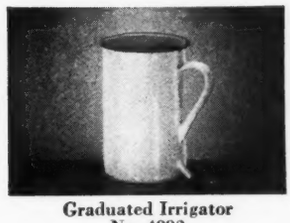
Solution Bowl
No. 4734



Utility Jar
Nos. 4782 and 4784



Graduated Irrigator
No. 4882

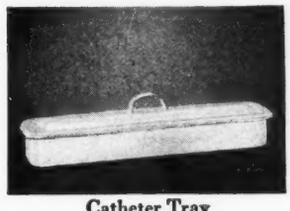


Graduated Irrigator
No. 4892

Bed Pan
No. 4901

Sterilizer
No. 1459

Shallow Instrument Tray
No. 4019

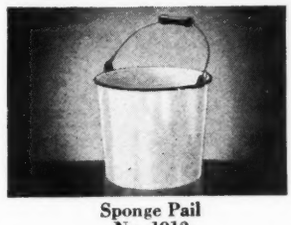


Catheter Tray
No. 4295

Instrument Tray
No. 3309-2

ITEMS COVERED BY ORDER L-30-b

Oval Foot Bath
No. 2609



Sponge Pail
No. 1912

Instrument Tray
Nos. 3416-2 and 3420-2

SPECIFICATIONS

No.	Capacity Qts.	Dimensions Inches	Case Lot Quantity	Wt.
4711	3-1/2	12-3/8 x 3-5/16	6	10
4860	15/16	9-7/8 x 4-1/2 x 2-1/8	6	4½
4741	15/16	6 x 2-1/2	6	3½
4734	7	13-9/16 x 4-5/8	3	8½
4782	2-5/16	5-1/2 x 6-11/16	2	4
4784	4-5/16	6-5/8 x 8-1/2	2	6
4882	2	5-1/8 x 7-3/8	2	3
4892	2	5-1/8 x 7-3/8	2	3½
4901	Adult Size	14 x 11-3/8	1	3½
1459	9-1/2	18-3/4 x 8-5/8 x 4-7/8	1	9
4019		19-1/8 x 12-5/8 x 3/4	6	20
4295		8-7/8 x 5 x 2	3	5
2609	9-7/8	17 x 13 x 5	3	12
1912	12	11-1/8 x 9-7/16	3	14½
3309-2	1-1/16	8-7/8 x 5 x 2	6	5½
3416-2	4-1/2	16-7/16 x 9-15/16 x 2-1/8	6	15½
3420-2	7-3/4	20-5/8 x 12-9/16 x 2-7/16	6	27½

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25,000 Tuberculosis Cases Will Be Detected in 1943, Pollak States

By the end of this year, it is estimated that 25,000 hitherto unrecognized cases of tuberculosis will have been discovered through the examinations conducted by the Selective Service System, by the U. S. Public Health Service in war industries and by the industries themselves in examining applicants for employment. But the tuberculosis hospitals of the country are being steadily depleted of employes, as are other hospitals.

Thus tuberculosis hospitals are caught between two millstones, according to an editorial by Dr. Maxim Pollak, medical director and superintendent of the Peoria Municipal Tuberculosis Sanitarium, Peoria, Ill., carried in the October issue of the *Peoria Fluoroscope*.

"Furthermore," writes Doctor Pollak, "tuberculosis institutions must extend their efforts in the face of the grave danger that the upheaval caused by the war will contribute to the spread of the disease and will change the hitherto favorable trend from the down to an upgrade."

Recently the American Red Cross authorized its local councils to assign volunteer nurses' aides to tuberculosis hospitals.

May Fall Short of Goal in Recruiting Nurses, Hospitals Are Warned

Three communications urging the expansion of clinical facilities for training student nurses were sent out September 30 by the National Nursing Council for War Service as a result of decisions reached by the board of directors of the council at its meeting on September 24.

Stella Goostray, chairman of the council, in a memorandum to principals of schools of nursing pointed out that the national goal of 65,000 new students this year will not be reached unless nursing schools admit more students than they plan to at present. She stated that even this number will not adequately meet the needs of civilian hospitals. A similar memorandum was also sent to administrators of hospitals having schools of nursing.

A third memorandum was addressed to state boards of nurse examiners requesting that they survey clinical facilities within their states which might supplement those now being used and encourage institutions with potential clinical facilities to make them available to existing schools of nursing.

Army-Navy "E" Awards

Army-Navy "E" awards have recently been granted to the following organizations for superior performance in producing war equipment: Smith, Drum and Company, Philadelphia; Standard Brands, Inc., Standard Margarine Company, Inc., Indianapolis; Barlow and Seelig Manufacturing Company, Ripon, Wis.; Hamilton Manufacturing Company, Two Rivers, Wis.; National Enameling and Stamping Company, Milwaukee; American Radiator and Standard Sanitary Corporation, Louisville Plant, Louisville, Ky.; Corning Glass Works, Wellsboro Plant, Wellsboro, Pa.; S. H. Pomeroy Company, Incorporated, Bronx Plant, New York; International Business Machines Corporation, Plant No. 4, Poughkeepsie, N. Y.

Army Hospital Dedicated

The completion and opening of Schick General Hospital, Clinton, Ia., were marked by dedication ceremonies held on October 7.

Blue Cross Reports Greatest Gains Since Plans Were Inaugurated

Blue Cross enrollment stood at 12,750,000 on October 1, including approximately 500,000 persons whose contracts have been suspended because they are in the armed forces, according to tabulations by the Hospital Service Plan Commission. This is a gain of approximately 500,000 during the third quarter and of 1,750,000 for the first nine months.

These are the largest gains for the third quarter and for the first nine months since the plans first started. The third quarter gain was 29 per cent higher than the gain for the same period of 1942 and 10 per cent above the 1941 figure. Figures are for the 77 approved plans.

Net gains of 10,000 or more in the third quarter were reported by the following 19 plans: Pittsburgh, 55,000; Newark, 44,000; Philadelphia, 38,000; Boston, 36,000; Cincinnati, 25,000; Milwaukee, 23,000; Cleveland, 21,000; New York, 19,000; Chicago, 19,000; Toronto, 17,000; Buffalo, 17,000; Baltimore, 17,000; Portland, Ore., 14,000; St. Louis, 14,000; Des Moines, 13,000; Durham, N. C., 11,000; New Haven, 11,000; Rockford, Ill., 11,000, and Denver, 10,000.

There are now nine plans with over 500,000 enrollment, namely, New York City, 1,373,000; Detroit, 973,000; Cleveland, 729,000; Pittsburgh, 648,000; Boston, 572,000; Newark, 546,000; St. Paul, 544,000; Philadelphia, 527,000, and Chicago, 526,000. The St. Paul plan lost 11,000 subscribers during the third quarter.

New York Hospital Group Acts to Solve Personnel Shortage

Appointment of nurses' aides to Army hospitals has prompted members of the Greater New York Hospital Association to recommend to the American Red Cross that in view of the acute shortage of hospital personnel any program for recruiting volunteer nurses' aides for Army hospitals should give due consideration to the needs of the voluntary hospital.

Last spring this association made a questionnaire study of personnel shortages which indicated that there were 4000 vacancies in the various classes of personnel, representing roughly 15 per cent of the authorized personnel. It is estimated that since that time these vacancies have increased to over 20 per cent.

The question has arisen in New York whether the War Labor Board has jurisdiction in a labor dispute involving a charitable institution. This has been instigated by the difficulties four member hospitals are having with the local branch of the State, County and Municipal Workers of America. The situation is now under advisement by a special committee.

A recent inquiry addressed to member hospitals asking whether they would approve a recommendation that nurses in new-born nurseries not be required to wear masks brought 26 replies—16 in favor of abolishing the mask and 10 opposed. The recommendation was made at the suggestion of various doctors who are of the opinion that unless a mask is changed every fifteen or twenty minutes it becomes a hazard rather than a safeguard.

Roosevelt Hospital Reports

"On a Mighty Mission" is the title of the 1942 annual report of Roosevelt Hospital, New York City, issued in October. The report has a large V on each two facing pages. Each arm of the V deals with one aspect of the hospital's work and shows how it is carried on by the hospital's evacuation unit in North Africa and how it is carried on at home. "A hospital effectively serving two fronts is indeed a mighty mission," says Thomas S. McLane, president. The report is largely pictorial.

DON'T YOU WISH there *were* such a nurse, these hectic wartime days? Unfortunately, it's almost impossible to give your staff more hands.

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Public Health in the Future Discussed at A.P.H.A. Meeting

Prerequisites to better public health were outlined by Dr. Joseph W. Mountin, assistant surgeon general, U. S. Public Health Service, Washington, D. C., speaking before the war-time public health conference of the American Public Health Association in New York October 12 to 14. They are: (1) to hold gains already made in raising general health levels; (2) to increase these gains by extending public health service now in operation to all segments of the population; (3) to broaden the definition of health service to include medical care, and (4) to explore the possibilities of research. He also recommended that some national agencies combine and then extend and redistribute medical personnel.

In considering the health plan of the future, there must be a more equitable distribution of physicians to assure adequate service to rural areas, Doctor Mountin believes. Some means must be devised of attracting not less than 25,000 physicians to rural communities.

Doctor Mountin sees the need of providing all areas as quickly as possible with health agencies staffed by trained medical officers. In the future, funds for local health service are likely to be derived in greater measure from state and federal sources than heretofore. With greater centralization of financing, the problem of amalgamation is likely to be less difficult.

A glimpse into the postwar city was provided by Prof. C.-E. A. Winslow, professor of public health, Yale University School of Medicine. As he sees it this should be developed as a whole with unity of purpose, not as the cities of today which developed through unregulated forces with no purpose. We need a master plan according to the population of the area, considering its agricultural and industrial future in relation to the outside world.

The health department of the future, in the opinion of Dr. Henry F. Vaughan, dean, school of hygiene and public health, University of Michigan, must concern itself with the broader interest of lives.

It is essential that the health administrator become a leader in the planning and coordinating of such programs even though they do not fall under his direct administrative supervision, Doctor Vaughan said.

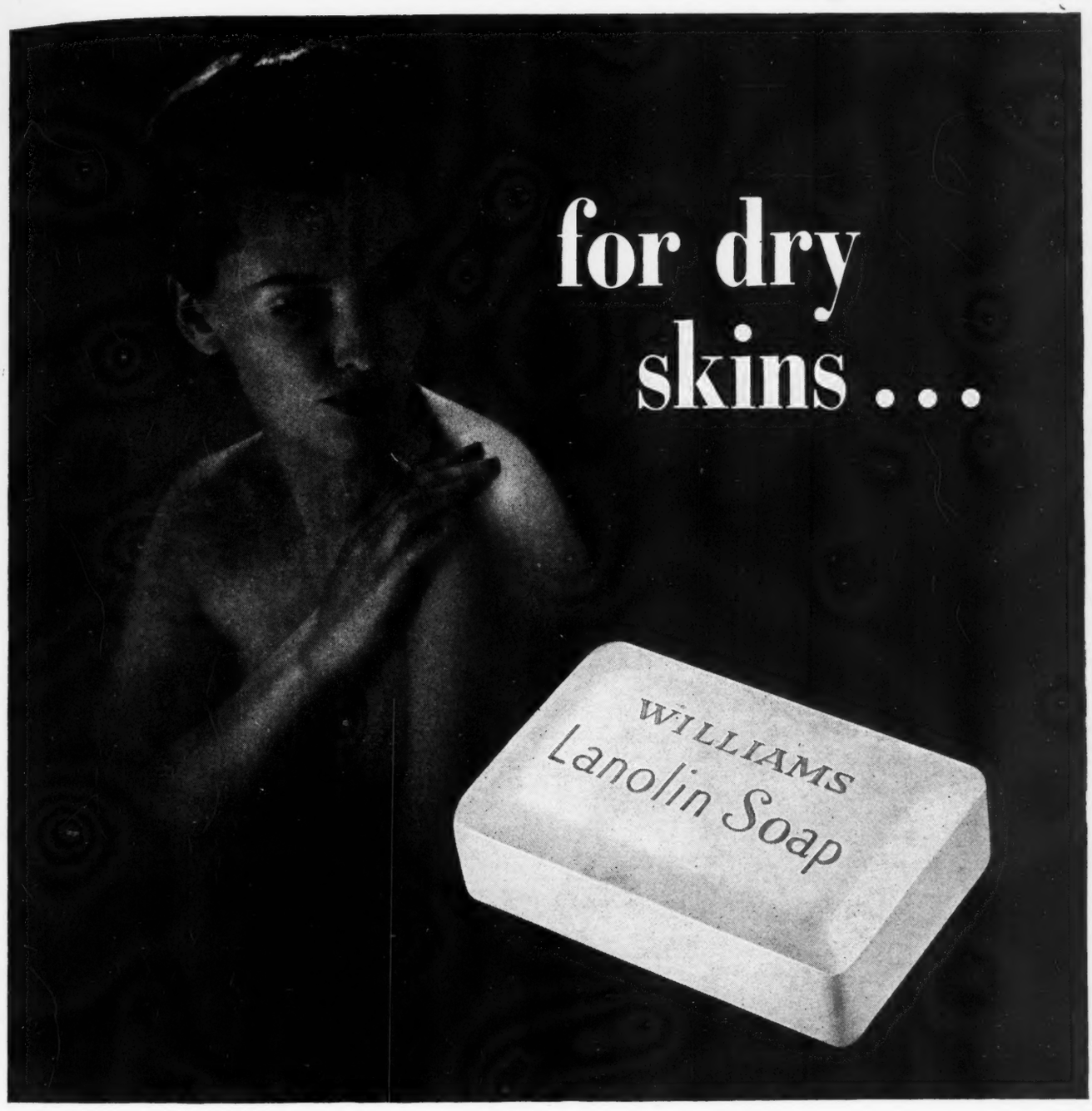
Public health of the future needs democratic planning and participation rather than autocratic dictation by government or vested interests, continued the dean.

The establishment as soon as possible of a permanent international health organization was urged by Surgeon General Thomas Parran.

New officers of the American Public Health Association for the coming year are: Felix J. Underwood, Jackson, Miss., president; Dr. John J. Sippy, Stockton, Calif., president-elect; Dr. G. H. de Paula Souza, São Paulo, Brazil; Dr. Jean Gregoire, Ottawa, Can., and Pearl R. Kendrick, Grand Rapids, Mich., vice presidents, and Louis I. Dublin, third vice president of the Metropolitan Life Insurance Company, New York, treasurer.

O.D.T. Urges Motor Maintenance

Proper maintenance of motor vehicles or other equipment in which liquid-cooled engines are used is the subject of a recent pamphlet issued by the Office of Defense Transportation under the title "Cooling System: Cleaning, Flushing, Rust Prevention, Antifreeze." In simple terms the illustrated brochure gives detailed instruction on checks and tests for cooling liquid losses; on routine maintenance of the cooling system; on the causes of overheating and overcooling; on the causes and prevention of corrosion and rust; on the prevention of clogging, and on the characteristics of various types of antifreeze and their use.



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Williams Lanolin Soap is completely free of fatty acids, dye and strong perfume. Finest quality oils are used in a way that precludes rancidity. Uncombined alkali is virtually non-existent.

Patients like the quick, rich lather of Williams Lanolin Soap. With its delicate scent and tasteful wrapping, it appeals to them as an uncommonly fine complexion soap. And since it is subjected to extremely high pressure in the making, it is long-lasting and economical.

Won't you accept a full-size cake of Williams Lanolin Soap with our compliments. Then you can observe its qualities at first hand. Just mail the coupon.

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This offer is limited to the medical and nursing professions. Please attach letterhead, card or other professional identification. Good only in U. S. A.

Transferring Gases From Large to Small Cylinders Is Dangerous

A strong warning to hospitals that the transferring of compressed gases from large to small containers is dangerous and should be discontinued promptly was issued by the Compressed Gas Manufacturers' Association on October 6. The practice is condemned by the National Fire Protection Association.

Reasons for this warning were given as follows: (1) the Interstate Commerce Commission has established regulations regarding maximum permissible filling pressures and densities for all of the various types of cylinders and manufacturers are thoroughly familiar with these regulations; (2) the hazard of overfilling small cylinders is always present and may lead to cylinder rupture; (3) an explosive mixture of gases may occur, since some hospitals return cylinders which are partially filled with a gas other than that originally shipped; (4) contamination of gases and the entrance of dangerous impurities may also result from this practice; (5) safety devices, valves and parts need frequent inspection service by the manufacturer.

New York Plan Inaugurates New Ward Service Contract

Associated Hospital Service of New York has obtained approval of 80 member hospitals to the new ward service contract, thus making this program a reality, it was announced at a recent meeting of the Greater New York Hospital Association.

The contract will sell for 56 cents a month for individuals and $1.32 for families, entitling them to all services customarily given ward patients up to twenty-one days of service per year with a 50 per cent discount on subsequent service for an additional ninety day hospital stay. To receive these accommodations, the subscriber must be eligible for admission to the ward under the rules of the individual hospitals. The patient who cannot qualify will be entitled to use of a semiprivate room upon payment of a small fee to the hospital.

Payments to the hospitals will be on a graduated scale, $9 for one day, $15 for two days, $20 for three days and so on, the rate for 10 days being $50 or $5 per day.

Although some disapproval of the plan was expressed by certain members of the Greater New York Hospital Association when the plan was presented at a recent meeting, the association voted in favor of its adoption.

Pullman Company Converts 78 Cars to Use as Hospital Trains

Conversion of the seventy-eighth Pullman car into a railroad hospital car for the Army medical department was announced by the Pullman Company on October 8. The company is now working on a final order for the conversion of 10 more of its sleepers. The new cars underwent thorough dismantling and conversion to become air-conditioned traveling hospitals each with a capacity of about 30 patients. All of the completed cars are now in service.

With the exception of a few units, the cars are of two general types: ward cars and ward table cars. The ward cars are arranged with 32 beds of the folding type in two tiers. An unusual arrangement makes it possible for each bed, both upper and lower, to be placed in a number of different positions. The cars are also equipped with washrooms, toilets and a receiving room that has a special loading door for stretcher cases.

The ward table cars have 15 double-deck beds with a capacity of 30 patients and the receiving rooms of these cars are equipped with operating tables, sterilizers, instrument cabinets and medical washstands. .

Each car is marked with a large red cross at each end on either side and a red cross is also painted on the roof.

Heidbrink Resuscitators

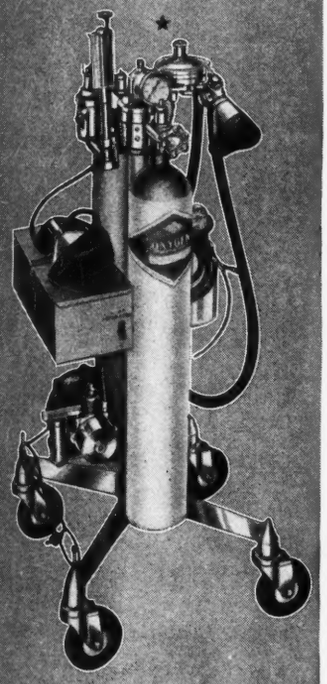
SAFE

★

SIMPLE

★

UNDER-STANDABLE



The "Accepted" seal denotes that Heidbrink Resuscitators, Models 51A and 20A, have been accepted by The Council on Physical Therapy of The American Medical Association.

RESUSCITATION is so clearly understood in all hospitals, that little need be said about treatments to induce inhalation and respiration. But the *safety* and *simplicity* of the equipment used *are* highly important factors in securing results.

Heidbrink Resuscitators are of two general types—one for use on new-born and very small infants; the other for older children and adults. Both are simple, safe and understandable.

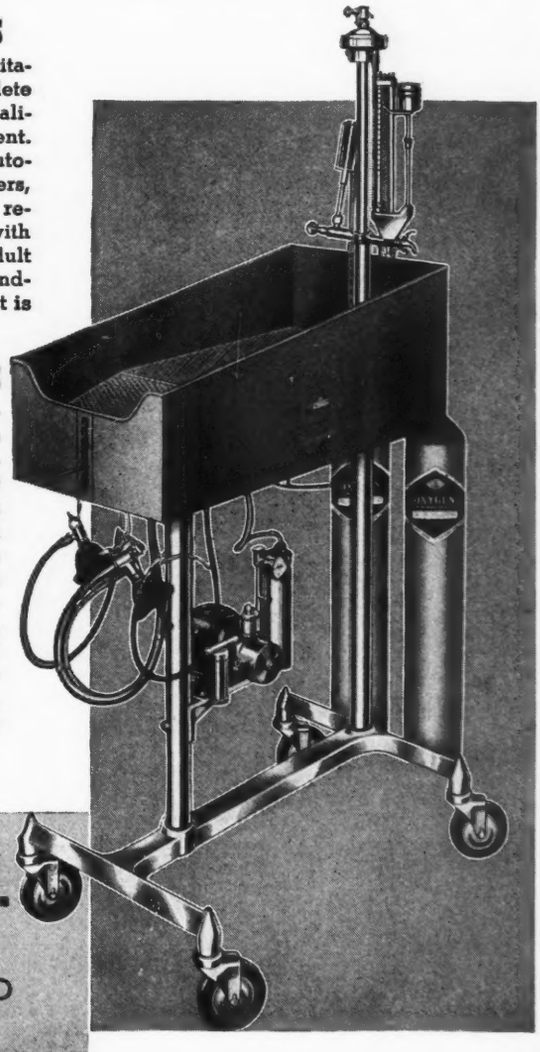
On models for infants the operator merely adjusts the automat to deliver the pressure selected for the type, size and age of patient, adjusts the escape valve of the water manometer and administers Oxygen rhythmically to simulate natural breathing. When breathing begins, Oxygen or Oxygen-air mixture is administered continuously. With adult models, the automat is set to deliver the selected pressure and the same technic applied as with models for infants.

STAND MODEL FOR ADULTS

Model 51A Heidbrink Adult Resuscitator includes operative head complete with calibrated automat, flowmeter calibrated for Oxygen and 80-20 percent. Helium-Oxygen mixture, two-yoke automatic regulator for D and E size cylinders, 3,000-lb. cylinder pressure gauge, resuscitation and inhalation inhalers with adult size interchangeable bodies, adult size catheter adapter, tubings, handwheel wrench. Complete equipment is mounted on a four-caster stand.

BASSINET MODEL FOR INFANTS

Model No. 20A for resuscitation, inhalation and aspiration. Includes operative head with automat, manometer and flowmeter, two-yoke automatic regulator for D or E size cylinders, electrically warmed bassinet with large drawer, perforated tray adjustable up and down at both ends, mattress, electrically operated aspirator, infant size resuscitation inhaler with airway, infant size inhalation inhaler, infant size catheter adapter and intratracheal catheter, tubings, handwheel wrench. Complete for use, mounted on heavy two-post stand with large noiseless casters.



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Plaster Casts Aid in Burn Treatment, Physicians Report

Close fitting plaster casts provide comfortable, rapid and uncomplicated healing of burns on the arms, legs and hands, it was reported in the *Journal of the American Medical Association* for October 2 by Drs. Stanley M. Levenson and Charles C. Lund of Boston. The method used involves no debridement, anesthesia or cleaning except for the removal of large pieces of loose, hanging skin.

One layer of sterilized petrolatum gauze is applied to the skin over the whole area to be covered by plaster. This is covered by four layers of sterile open-mesh gauze, which is fitted carefully without overlapping. Thin plaster slabs are then molded over the extremity front and back and a thin layer of rolled plaster completes the light well-fitting bandage which extends 3 or 4 inches above the burn.

The cast is left in place for fourteen days and if the burn has not healed at the end of that time, another cast is applied. The 22 patients treated, it is reported, have stated that as soon as the plaster cast was applied the pain disappeared.

Coming Meetings

Nov. 9-10—Kansas Hospital Association, Hotel Jayhawk, Topeka.

Nov. 10—Colorado Hospital Association, Denver.

Nov. 18-19—Missouri State Hospital Association, Hotel Chase, St. Louis.

Dec. 2—American Registry of X-Ray Technicians, Drake Hotel, Chicago.

1944

Jan. 16-29—Inter-American Hospital Association, Mexico City.

Feb. 18-20—National Association of Methodist Hospitals and Homes, Claypool Hotel, Indianapolis.

March 6-8—Blue Cross Plans, Midwinter Conference, Statler Hotel, Detroit.

March 15-17—New England Hospital Assembly, Hotel Statler, Boston.

April 12-14—Hospital Association of Pennsylvania, Hotel William Penn, Pittsburgh.

April 25-27—Ohio Hospital Association, Neil House, Columbus, Ohio.

May 10-12—Tri-State Hospital Assembly, Palmer House, Chicago.

May 22-26—Canadian Medical Association, Royal York Hotel, Toronto, Ont.

June 26-30—Canadian Nurses' Association, Winnipeg, Man.

No Pay Checks—Workers Walk Out

Too many payless pay days caused more than half of the 700 employes at Kankakee State Hospital, Kankakee, Ill., to go on strike October 18. Although 565 workers joined the walk-out, Rex Gowler, supervising male nurse and state vice president of the State Council of Institutional Employees (A. F. of L.), ordered 200 back to their posts to keep the hospital from complete disruption. Explaining that for the last three months pay checks had been held up for as much as four weeks, the union spokesman stated that in the future the workers expect to receive their pay "not later than the tenth of the month following the four week period during which it was earned." The arrival of the checks on October 20 ended the strike.

Rehabilitation Council Set Up

Twenty leaders in the field of training for the handicapped have been appointed to a national rehabilitation advisory council, it has been announced by Paul V. McNutt, Federal Security Administrator. The council will advise the recently established Office of Vocational Rehabilitation on problems encountered in the expanded federal-state program for the rehabilitation of the handicapped. At the first meeting of the council on October 8, it was estimated that approximately 1,500,000 persons may be eligible for rehabilitation under the program.

Michael Reese Gets Bequest

Michael Reese Hospital, Chicago, has received a bequest of $28,825 under the will of the late Sidney L. Morgenthau, an inheritance tax report filed in County Court revealed recently.

New Developments in Syphilis, Tuberculosis Control Reported

Two new developments in chemotherapy that have been reported in the press recently are the use of penicillin as a "swift and safe" cure for syphilis, and a chemical compound which holds promise of controlling tuberculosis chemically.

At a meeting of the American Public Health Association, Dr. John F. Mahoney, U. S. Public Health Service, disclosed that four patients, given 120 grains of penicillin each, had lost all traces of syphilis symptoms within four months. They were given the drug intramuscularly and had no other treatment. It was reported that penicillin is the first drug that has brought about the desired results in syphilis treatment without injuring the victim.

The new chemical for the control of tuberculosis is known as diasone. It was synthesized in 1937 by chemists in the Abbott Laboratories and has been under study ever since. Dr. George W. Raziss in a recent article revealed that it is now believed to offer hope in treating tuberculosis. However, it was emphatically stated by S. Dewitt Clough, president of the company, that the drug is not available for public distribution and that it will not be made available until tests on human patients shall have proved its efficacy and demonstrated that it has no bad after-effects.

Bellevue Hospital Employs Riker's Island Prisoners

Bellevue Hospital, New York City, has installed 30 prisoners from Riker's Island who are serving terms of from thirty days to six months for various petty offenses to work out their terms in the hospital. The prisoners will work as painters, carpenters, handymen and orderlies and will be paid $1 per day and their meals. Their pay will be issued at the end of their terms.

Prisoners who have a record of good behavior at the hospital may keep their jobs after their sentences have been served, hospital officials stated. Dr. Edward M. Bernecker, commissioner of hospitals, stated that if the experiment works out satisfactorily at Bellevue, it might be followed at other hospitals.

Criticism of the program was leveled by Judge Franklin Taylor of the Kings County Court, who has ordered the practice investigated. However, it has been defended by Mayor F. H. La Guardia as being made necessary by the acute shortage of manpower.

Suggest Ways to Use A.H.A. Funds

Members of the American Hospital Association were urged by President Frank J. Walter on October 14 to suggest types of activity that they wish the association to undertake with the additional funds that will become available under the increased schedule of dues. Mr. Walter stated that part of the increased revenue will be used to finance the Wartime Service Bureau, promote a national public education program and assistance in local public education, strengthen the council on association development to correlate activities between the national and the regional associations, provide added personnel to other councils and finance the regular expenses of the headquarters office from dues with convention exhibit income used only for special projects.

Wesley Buys Apartment Hotel

The purchase of Hampshire House, an 18 story apartment hotel at 201 East Delaware Place, by Wesley Memorial Hospital, Chicago, for use as homes for nurses has been announced by John Holmes, president of the board of trustees. The use of the hotel will permit the hospital to make available to the Navy Department additional quarters in the hospital to take care of Navy personnel.

Army Hospital at Hines, Ill., Will Have Capacity of 1500

Covering an area 3500 by 1000 feet, the new Army hospital unit now under construction at Hines, Ill., will comprise 50 buildings with a capacity of 1500 patients. Army officials expect it to be available by April 1, 1944. The 50 buildings will be connected by brick passageways and the hospital area will be interlaced with streets; six or seven parking lots will be provided.

In addition to 14 wards to house the patients, quarters will be provided for nurses and officers. Units will also be erected for administrative offices, a guest house, clinics, mess hall and warehouses.

The new hospital will care for wounded soldiers and also will receive patients from station hospitals at Army camps. It will not be an addition to the old Hines Hospital, although officials said there is a possibility that the new facilities might be turned over to the present hospital sometime after the war.

International Council Meets

First steps in building international cooperation among hospitals will be directed to the hospitals of North and South America, Dr. Malcolm T. MacEachern announced after the first meeting of the newly formed Council on International Hospital Relations held in New York City on October 7. Many of the hospitals in Europe have slipped years behind current hospital practice because of the war, Doctor MacEachern said. "There must be a program that will begin automatically to help hospitals of war-torn nations get back on their feet so they can administer to the tremendous needs of their populations." No details about such a program were disclosed.

Celebrates Sixtieth Anniversary

Diamond jubilee ceremonies to be celebrated on November 6 by Presbyterian Hospital, Chicago, will lack the glitter that might have accompanied them in nonwar years but the tribute that will be paid to the men and women who have aided the hospital during its sixty years of community service will be simple and sincere. Members of the board of managers and women's board, medical staff, leaders in the hospital field and other friends of the hospital will witness the presentation of a plaque to Dr. James B. Herrick in honor of his services to the hospital at an informal reception to be held at the Sprague Home for Nurses.

Washington Jangos Graduated

WASHINGTON, D. C.—The Jango Junior Nurses, probably the youngest nursing unit in the United States, were graduated and capped October 15 in the auditorium of the District Medical Society Building, Washington, D. C. Maj. Gen. Norman T. Kirk was the principal speaker at the ceremony. A branch of the Junior Army-Navy Guild Organized Services, the Jango Junior Nurses, daughters of officers in the armed services, were organized in Washington, D. C., and now have branches in Chicago and other cities. The young girls, average age about 15, have completed a course of training in nurses' aide work and each has given two hundred hours of duty in Doctors Hospital.

Simmons Opens Red Cross Drive

A vigorous campaign to enroll women in American Red Cross home nursing classes was announced last month by the Simmons Company of Chicago. Advertisements will appear in national magazines with a combined total circulation of more than 32,000,000 copies. Window displays, elevator and counter cards, giant posters and small "eyecatchers" to be used in local advertising are provided by the company to its local dealers and salesmen.

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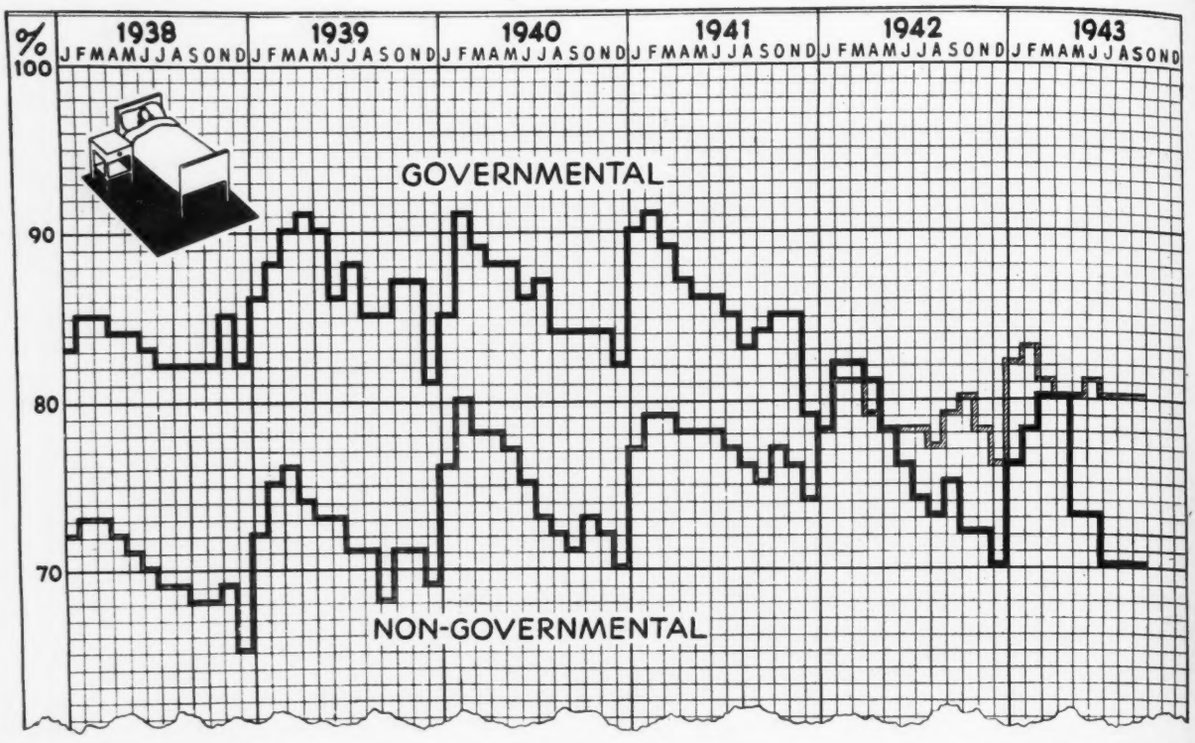
80 Per Cent Occupancy in Voluntary Hospitals



Preliminary reports gave an occupancy of 80 per cent for the nongovernmental general hospitals for July, August and September and of 70 per cent in governmental general hospitals for the same period. The average for the first nine months is 81 per cent for nongovernmental and 74 per cent for governmental hospitals.

Thirty-two hospital construction projects were reported from September 20 to October 19, with 25 giving costs of $4,309,135. More than one fourth of the amount was for nurses' homes. Net total construction for 1943 is $84,234,000.